HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE
PREPARED BY THE DEPARTMENT OF HEALTH
AND SOCIAL SECURITY

VOLUME 15, NO. 1, ABSTRACTS 1-155. JANUARY 1979

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British Journal of Anaesthesia, 4 Little Essex St., London WC2R 3LF.
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Journal of the Institute of Health Education, Institute of Health Education, 14 High Elms Road, Hale Barns, Cheshire, England.

Journal of Long-Term Care Administration, American College of Nursing Home Administrators, 4650 East-West Highway, Washington, D.C. 20014, U.S.A.
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Journal of Oral Surgery, American Dental Association, 211 E. Chicago Ave., Chicago, Ill. 60611, U.S.A.
Medical Journal of Australia, P.O. Box 116, Glebe, N.S.W. 2037, Australia.
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New Zealand Hospital, Paragon Chambers, Cable Car Lane, Wellington, New Zealand.
Nursing Administration Quarterly, 20010 Century Boulevard, Germantown, Md. 20767, U.S.A. $9.75
Nursing Mirror, Surrey House, 1 Throwley Way, Sutton, Surrey SM1 4QQ, England. £0.18
Nursing Times, Macmillan Journals Ltd., Little Essex St., London WC2R 3LF. £0.18
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HOSPITAL ABSTRACTS

Vol. 19 January, 1979 No. 1

HOSPITALS IN GREAT BRITAIN

1. DAVIS, S. E. **The contribution of the nursing home.** *Royal Society of Health Journal*, London, 1978, June, vol. 98, no. 3, pp. 132-134.

With very rare exceptions, any non-government/non-National Health Service (NHS) premises in Great Britain for the care and treatment of patients must be registered with an area health authority (or health board in Scotland) under the Nursing Homes Act 1975 and regulations under it. There are approximately 1,200 such independent nursing homes with about 32,000 beds (about eight to nine per cent of the NHS capacity). They are heavily oriented to long-stay care, primarily of old people. Recent legislative history has compounded confusion as to public responsibility for and the scope of long-stay care, particularly for the aged. There is unlikely to be much improvement in the position in the immediate future. The cost per patient in NHS long-stay units is higher than the generality of independent nursing home fees. Area health authorities may use and pay for independent beds for NHS patients, but they are reluctant to do so. It is contended that independent nursing homes, clinics and hospitals are today contributing a necessary and high standard of professional care to supplement NHS services and, if permitted to do so, are capable of increasing this contribution.

2. HOADLEY, D. M. **The NHS—the continuing need for private nursing homes? Interdependence and co-existence.** *Royal Society of Health Journal*, London, 1978, June, vol. 98, no. 3, pp. 130-131.

The decision to phase out private beds from National Health Service (NHS) hospitals must inevitably have consequences on the care provision levels in the private sector. Current provision in the private sector in Great Britain is 32,103 beds. Most of these are for general medical, convalescent and geriatric patients; it is safe to assume that these beds are occupied mainly by the elderly and mainly on a long-term basis. The large private hospitals have X-ray, laboratory and similar facilities, but are not strategically located to provide them to smaller private nursing homes, and they are likely to continue to be provided by the NHS on a repayment basis. At the end of 1976, 3,133 beds in private hospitals were occupied by NHS patients on a contractual basis. If the private sector geriatric and long-stay provision was to be removed overnight, some area health authorities would face a situation of national disaster proportions. When the remaining private beds in NHS hospitals have been phased out, there will be a total physical separation of the public and the private sectors. This separation has implications for the private sector and it may be necessary to increase provision of beds, especially in the acute surgical and medical specialties.

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 33, 35

3. Plaats en functie van het academisch ziekenhuis. **[Position and function of the teaching hospital.]** *Ziekenhuis*, Utrecht, 1978, Aug. 2, vol. 8, no. 15, pp. 384-386.

The paper is a report on speeches by several speakers on the occasion of the 75th anniversary of the Groningen Academic Hospital. The task of teaching hospitals is twofold: the provision of a health service, and provision for teaching and research. New medical developments create a greater demand which is not correspondingly met by provision for increases in staff and equipment. A call is made for more integration of teaching hospitals in the health services while maintaining their academic functions, research and clinical care, and receiving subsidies both as a health service and as a teaching hospital. The size and functions of teaching hospitals should be clearly defined. According to a study by the College of Hospital Provisions a minimum of 860 beds is essential for maintaining an efficient medical training school. In projecting a new teaching hospital consideration has to be given to the type of teaching faculties, the estimated student intake and medical requirements of the district. A medical training programme, affiliation with other hospitals and continuation of advanced training are suggested, as well as greater co-ordination of teaching hospitals with the complementary health services and increased involvement of non-teaching hospitals with training of students and medical specialists.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract Nos. 34, 35, 90, 106

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

4. Neubau der Universitätskinderklinik Bern. **[New building for the University Children's Hospital, Berne.]** *Veska*, Aarau, 1978, Aug., vol. 42, no. 8, pp. 395-401.

The new building for the 269-bed Children's Hospital, Berne, which forms part of the Insel Hospital, was completed in 1977. It consists of a nine-storey ward block, a treatment and laboratory wing and a wing containing lecture hall, nursing school, classrooms, and library. There are three subground floors: the upper two floors house physiotherapy, kitchens and staff restaurant etc., while the lower floor houses the civil defence emergency hospital. The hospital is constructed on a 136 cm. module and moveable dividing walls allow a four-bedded patient's room to be converted easily into two two-bedded rooms. There is a school and kindergarten for patients and a playroom for the young children of visitors. Unlimited visiting is allowed. The paper is illustrated with sketch plans, schematic drawings, organization charts and four photographs.

DESIGN OF SPECIAL HOSPITALS OR UNITS

5. **Ingenious design meets budget, space constraints for hospital's community mental health center.** *Hospitals*, Chicago, 1978, April 16, vol. 52, no. 8, pp. 41-44.

The community mental health centre at Genesee Hospital, Rochester, N.Y., is on

the two floors vacated by the hospital's department of medicine and renovated with a limited budget. It has been designed on the principles that the patients were worthy of an attractive facility and that the environment should correspond as much as possible to the patient's normal environment. The centre accommodates 35 in-patients and provides ambulatory care, partial hospitalization and day care. On the lower floor are the reception and waiting area, staff and secretarial offices, staff lounge, medical records, group therapy room, and quiet room. On the upper floor are patients' rooms, dining room, kitchen, activities rooms and night patient/conference room. There is no nurses' station per se but a reception desk and work areas that are open and accessible to patients. Each in-patient room is furnished simply but attractively with beds, a rocking chair and a straight chair, built-in sink and counter-top, built-in cupboard and luggage storage space, and toilet and shower. Plans of each floor and four coloured photographs are included.

WARDS AND PATIENTS' ROOMS

6. BROWN, W. T. **Owed to the Nightingale-2: ward evaluation.** *Nursing Times*, London, 1978, Aug. 3, vol. 74, no. 31, pp. 1279-1284.

A ward evaluation at St. Thomas' Hospital reviewed the three types of wards built over 100 years. The South Wing includes wards built in 1871 in accordance with Florence Nightingale's design; the 11-storey ward block, the East Wing, was opened in 1966; and in 1976 the 13-storey North Wing block, with wards with bays, was completed. Four wards were selected for detailed study in each of the three wings. Each of the 16 sisters answered questionnaires and 235 patients were interviewed. The sisters described the advantages and disadvantages of the different types of wards under a number of headings including: (i) organization and control; (ii) facilities; (iii) physical comfort of patients; (iv) communications; (v) learning; and (vi) working conditions. Patients in general seemed well satisfied with the level of care and the friendly atmosphere irrespective of the ward type. While facilities might be less good in the old style wards, the spread of information was better. The report shows that, given a certain amount of money for upgrading the facilities, Nightingale wards are far from hopelessly out-dated.

ENGINEERING SERVICES

7. Organizacion del departamento de ingenieria y mantenimiento. **[Organization of the department of engineering and maintenance.]** *Policlinica*, Barcelona, 1978, July/Aug., no. 48, pp. 10-13, 16-18.

This excerpt from the AHA Hospital Engineering Manual describes the organization of the hospital engineering and maintenance department. The main responsibility of the department is maintenance, and in particular, the day-to-day maintenance of electrical and mechanical systems. The department should also provide advice on the planning and construction of installations, on the purchase of equipment, and on safety measures. The article includes lists of records relating to plans and specifications, security installations, contracts, electricity supplies, etc., which should be kept by the department. Three operation charts are included.

8. DEPARTMENT OF HEALTH AND SOCIAL SECURITY and WELSH OFFICE. **Health building engineering installations: commissioning and associated activities.** 2nd edition. (Health Technical Memorandum 17) London, Her Majesty's Stationery Office, 1978, 6pp. £0.55

This Technical Memorandum replaces the one produced in 1967 and has been revised to take into account the experiences of Health Authorities and other bodies which have been concerned with the commissioning of engineering installations in buildings and developments in commissioning practice since 1967. This Memorandum describes points which should be observed by those carrying out the design, construction, commissioning and testing of health building engineering installations. There are five chapters: scope; definitions; commissioning; associated activities including (a) design and tender preparation; (b) construction stage; (c) post-handover tests and adjustments, and (d) evaluation of design-in-use; and documentation.

COMMUNICATION SYSTEMS

See Abstract No. 80

TRANSPORT IN GENERAL

See Abstract No. 109

HEATING

See also Abstract No. 37

9. À Rennes: le Centre de gériatrie de Chantepie: un exemple d'établissement hospitalier "tout gaz naturel". **[The Chantepie geriatric centre, Rennes: an example of an 'all-natural-gas' hospital.]** *Argus des Collectivités*, Paris, 1978, Aug./Sept., vol. 26, no. 301, pp. 21-23.

The new 350-bed Chantepie Geriatric Centre in Rennes is a six-storey building which has a total area of 22,000 square metres. Natural gas provides the energy for the hot water for heating, washing, and steam, and also for the incinerator. The kitchen has gas cookers, and an autoclave, a percolator, and a dishwasher supplied with steam. The kitchen is designed to produce 500 meals at a time. The hot water is accumulated, regulated, and distributed in a substation within the main building. Heating is provided through hot water radiators except in the swimming pool, surgical station, and passages where warm air heating is used. This description includes a diagram showing the distribution of water and steam, and six photographs of equipment.

VENTILATION AND AIR-CONDITIONING

See Abstract No. 9

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 7

10. CUNNINGHAM, L. and WRIGHT, L. **In-house staff designs energy-saving system.** *Hospitals*, Chicago, 1978, April 16, vol. 52, no. 8, pp. 121-122, 124, 126.

With a relatively small amount of money and a lot of ingenuity, the innovative engineering team at the Kaiser Foundation Hospital and Rehabilitation Center, Vallejo, Calif., developed a successful pilot programme that resulted in substantial energy and financial savings. Using commercially available component parts, the team designed a preventive maintenance and energy-saving microprocessor system that is specially geared towards the hospital setting. The system, which uses a microcomputer and terminal printer, is described in detail. Flexibility is the key to the system, which was completed for approximately 25 per cent less than the cost of vendor-designed systems.

EQUIPMENT, FITTINGS, FURNITURE

EQUIPMENT GENERALLY

11. NORTON, D. **Equipment fit for purpose.** *Nursing Times*, London, 1978, July 6, vol. 74, no. 1109, Occasional Papers, pp. 73-76.

There are some 90,000 functional articles and commodity items in a modern general hospital and it seems sensible to consider whether bulk buying of standardized items could both cut costs and improve standards. Articles suitable for standardization are those where functional requirements do not vary with use. Firstly, however, a system of product appraisal and an index of nursing equipment and its users would be needed. The author describes in detail how the research process can be used in specifying and evaluating equipment. There are three types of enquiry: (i) what is wanted; (ii) how it performs; and (iii) which item is best. When functional specifications have been made a search must be made for products to fit them. Then a systematic and comparative evaluation must be carried out to assess 'fitness for use'. A data collecting instrument must be developed and field trials, where appropriate, be carefully planned and carried out.

BEDS, COTS, ETC.

12. MCCLEMONT, E. and others. **Simpson-Edinburgh low-pressure air bed: an early clinical evaluation.** *Paraplegia*, Edinburgh, 1978, Aug., vol. 16, no. 2, pp. 154-159.

A simple, inexpensive low-pressure air bed has been developed for use in situations where decubitis ulcers may arise. This bed is currently being evaluated for patients with special injuries, both in the hospital and in the home. Early experience is encouraging as regular turning of the patient can be safely omitted. The results indicate that the widespread use of the bed could greatly decrease the incidence of pressure sores.

ELECTRONIC EQUIPMENT

See also Abstract Nos. 102, 103, 134

13. ABRAMS, H. L. and MCNEIL, B. J. **Computed tomography: cost and efficacy implications.** *American Journal of Roentgenology*, Springfield, 1978, July, vol. 131, no. 1, pp. 81-87.

Because computed tomography is unique, it has been accepted by physicians with unrestrained enthusiasm. However, the capital investment and cost of maintenance are high, and there has been no orderly programme of dispersion despite the profound interest of the regulatory agencies in cost containment. Although the diagnostic accuracy of computed tomography in both the head and body is high, its information gain over other competing imaging methods, particularly those in the abdomen (ultrasound, nuclear medicine), has not been fully documented. In evaluating the cost-effectiveness of computed tomography, long-term outcome, while the most important criterion, requires carefully controlled studies over many years. Short-term value may be measured by assessing: the degree to which computed tomography furnishes new diagnostic information; its accuracy; its effect on the morbidity and mortality of diagnostic and therapeutic procedures; its impact on treatment planning; and changes in cost and savings incident to its use. Prospective studies must relate the contribution of computed tomography to that of competing methods and document the impact of additional diagnostic information.

STAFF GENERALLY

STAFF COMPLEMENTS

See also Abstract Nos. 26, 90

14. STRAKER, M. and CUMMINGS, J. **Staffing patterns and team composition.** *Hospital and Community Psychiatry*, Washington, 1978, April, vol. 29, no. 4, pp. 243-245.

The authors describe the work of a Veterans Administration task force in developing guidelines for staffing patterns and team composition on a hospital in-patient ward. The task force defined the objectives of treatment, the needs of patients and their families, the types of professionals constituting the mental health team, and the functions they performed. The specific activities required in providing patient care, the staff involved and those who could be involved with more training were also identified. The task force felt that the role of the patient as a participant needed special emphasis since patients were often undervalued and underused as contributing members of the health care team.

RECRUITMENT

See Abstract No. 28

CONDITIONS OF SERVICE

See Abstract Nos. 36, 120

STAFF MANAGEMENT

15. HINKLEY, N. E. **Staff development: a frill, a requirement or a necessity?** *Journal of Long-Term Care Administration*, Washington, D.C., 1978, vol. 6, no. 2, pp. 12-19.

Briefly stated, staff development in long-stay care is an on-going educational/training programme that addresses itself to the learning needs of staff, residents and families that are relevant to the provision of quality care. Three possible administrative attitudes to staff development are discussed: negative, neutral, and positive. The administrator with a positive attitude knows that he cannot afford to be without a staff development programme. He recognizes that although education and training schemes are not the panacea for every problem situation that occurs, relevant and integrated education/training opportunities are indeed a necessity for individual and organizational growth and ultimately for improvement in the quality of care.

STAFF RELATIONS

16. NOBLE, W. F. **A pragmatic approach to joint consultation.** *Hospital and Health Services Review*, London, 1978, July, vol. 74, no. 7, pp. 220-223.

This paper describes the transition over three years of consultative arrangements between management and staff at the Middlesex Hospital and Horton Hospital, Epsom. It was decided to recommend that a formal joint staff committee should be established at each hospital, each of which would include representatives of senior management and of trade unions and staff associations, drawn from six functional groups. Joint staff committees representing different sectors were also proposed. However, shop stewards refused to meet as part of a joint staff committee, resulting in the continuation of separate management/shop steward meetings. Two unions affiliated to the Trades Union Congress have now joined the joint staff committee, and the staff side now includes two representatives from each functional group. Thus, the original scheme for change has been successfully adapted to ensure the success of the exercise.

STAFF TRAINING

See also Abstract Nos. 15, 27, 28, 121, 135, 136

17. MUNK, R. J. and LOVETT, M. **Hospitalwide education and training.** Chicago, Hospital Research and Educational Trust, 1977, xi, 67pp. $8.00

The rapid expansion of in-service education schemes in hospitals in the United States led to the development of the five-year Hospitalwide Education and Training Project (HETP) carried out by the American Society for Health Manpower Education and Training, supported by a grant from the Kellogg Foundation, from 1972 to 1977.

The Trust selected 33 demonstration sites, including 16 individual hospitals and 17 consortiums of institutions, for participation in the HETP. Because of the organizational differences between the two types of site and the differences in approach in examining them, the single hospitals and the consortiums are discussed separately. The findings of the HETP are analyzed.

18. LEUZINGER, A. Weiterbildung—Eine Herausforderung an unsere Krankenanstalten. **[Further training: a challenge to our hospitals.]** *Veska*, Aarau, 1978, Aug., vol. 42, no. 8, pp. 425-432.

This is the text of a talk given to administrators of Swiss psychiatric hospitals. It sets out in some detail the objectives of the modern psychiatric hospital and lays down the basic requirements for successful hospital management. One of the most important factors in attaining the desired goals is the proper basic and further training of staff of all types and of all grades. The five different types of training are set out in diagrams which indicate how training is carried out, who is reponsible for it, the means used, the staff who take the training, and the subjects taught. The five types are: 'on the job' training; formal further training; leadership training; general training; and teaching those not employed in the hospital.

STAFF WELFARE

19. BERGERON, J.-L. La satisfaction au travail: résultats d'une recherche effectuée en milieu hospitalier. **[Job satisfaction: results of a hospital study.]** *Administration Hospitalière et Sociale*, Montreal, 1978, May/June, vol. 24, no. 3, pp. 35-41.

A questionnaire containing 150 questions relating to job satisfaction was completed by a sample of 52 managerial, 70 clinical, and 54 non-clinical employees in a 325-bed hospital which had a total staff of 1,000. Examples of some of the questions are given, and the results are presented in nine tables. These suggest that managerial staff generally achieved more job satisfaction than non-clinical staff; managerial staff were more satisfied with their salaries than the clinical staff and these in turn were more satisfied with theirs than the non-clinical staff. The latter, on the other hand, were more content as regards security of employment than the managerial grades. All three groups expressed less satisfaction about their chances of promotion than about any other area of work.

20. CHERNOCK, N. B. **A study of employee lateness.** *Journal of Long-Term Care Administration*, Washington, D.C., 1978, vol. 6, no. 2, pp. 30-48.

Before implementing a more definite and specific regulation on lateness, Clove Lakes Nursing Home and Health Related Facility, Staten Island, N.Y., decided to study the extent of the lateness problem. All the attendance record cards were collected for the nursing staff on the nursing home (99) and health related facility (62); lateness among staff employed for the whole of 1976 was analyzed. The results are presented in five graphs and 10 tables. The principal findings were: (i) lateness seemed to occur more frequently in the winter; and (ii) 17 per cent of the total sample had never been late, and, on average, 57 per cent had been late no more than once a month, 12 per cent had been late at least once but not more than twice a month, nine per cent had been late

at least twice but not more than three times a month, and five per cent had been late more than three times a month. Total lateness time was calculated to be 276 hours for the nursing home and 136 hours for the health related facility. The cost of the lateness of nursing staff was estimated to be £1,113.6; for the whole staff of the organization it would be $1,341.78. If the proposed regulation were introduced, at least 25 per cent of the nursing staff would have been dismissed, but it is unlikely that so many staff would have been late if they knew of the regulation.

21. CLODE, D. **Danger: major obstacles ahead: Health and Safety at Work Act.** *Health and Social Service Journal*, London, 1978, Aug. 4, vol. 88, no. 4602, pp. 872-874.

The Health and Safety Executive has recently published the results of a survey conducted into health and safety in hospitals in the North West Thames Regional Health Authority. The most serious environmental problem was in the control of temperature and ventilation, especially in operating theatres and casualty departments. Lifting of goods and patients is also a hazard, particularly for nurses, and could be alleviated by the provision of suitable equipment. The survey found that the maintenance of electrical equipment and the storage and supply of flammable liquids was often unsatisfactory. Frequently, there was inadequate control of infection sources in the pathology laboratory and those arising from disposal of waste. The report should help to make hospital administrators more aware of their responsibilities under the Health and Safety at Work Act of 1974.

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

22. WILLIAMS, K. J. **The role of the medical director.** *Hospital Progress*, St. Louis, 1978, June, vol. 59, no. 6, pp. 50-57.

The medical director can be defined as the official appointed by the hospital's board of trustees to be in charge of all affairs which affect the medical staff. He is a full-time salaried physician whose job is mainly administrative, requiring managerial and organizational skills. He is directly responsible to the chief executive officer and his responsibilities include: (i) making sure that audit and surveillance systems are established and maintained; (ii) ensuring medical staff comply with regulations; and (iii) ensuring that professional standards with regard to appointments are adhered to. The author discusses some situations which may lead to conflict between the administration and the board when a medical director is appointed and lists the changes in organizational structure which are inevitable. A careful examination of these changes should precede any decision to make such an appointment.

MEDICAL STAFF

See Abstract No. 122

NURSING STAFF

See also Abstract Nos. 20, 88, 126, 146

23. YURA, H. and WALSH, M. B. **The nursing process: assessing, planning, implementing, evaluating.** 3rd edition. New York, Appleton-Century-Crofts, 1978, xiv, 266pp. £7.65

The developments since 1973 which have taken place in the United States and have significantly affected nursing and the nursing process are identified and discussed. The book is divided into five chapters: chapter one briefly reviews the historic background and current ideas of the nursing process; chapter two reviews some of the theories fundamental to and related to the nursing process; chapter three analyzes the components of the nursing process; chapter four considers the application of the nursing process; and chapter five discusses the future of the nursing process. Four appendices are included which consider: national and international codes for nurses; selected observations made using the four senses; definitions and ABCD's of nursing process phases; and the application of nursing process to sensory deprivation. A bibliography is included (pp. 229-259).

24. DOWNS, F. S. and NEWMAN, M. A. **A source book of nursing research.** 2nd edition. Philadelphia, Pa., F. A. Davis, 1977, x, 200pp. £5.20

This book is intended for instructors and students of courses in nursing research with the aim of suggesting possible further areas for research. The book is in three sections: (i) elements of a research critique, in which the research process is evaluated, and questions relating to each section of a research design are included as guidance for the reader; (ii) evaluation of nursing intervention; and (iii) exploration of indices of health. Thirteen selected studies are described which bring together a range of emphases, designs and methodologies. An appendix is included which presents a critique of 'An Abstract for Action', the report of the National Commission for the Study of Nursing and Nursing Education.

25. LORENSEN, M. Dansk Sygeplejeråds forskningsfond. **[Uses made of the Danish Nursing Council's Research Fund.]** *Sygeplejersken*, København, 1978, July 19, no. 28, pp. 12, 19.

In 1973 the Danish Nursing Council set up a fund to support relevant research, and the first report was published in March 1977. Grants can be made for: (i) training in research methods in Denmark or abroad; (ii) pursuit of or participation in research or training; and (iii) loss of earnings in association with research. Active nurses may apply for grants, applications being accompanied by a detailed statement of aims, and references confirming status and suitability. The grants are administered by a four-person committee charged with responsibility for initiating research activities, handling applications for grants and making the necessary recommendations, and maintaining contact with recipients. Projects which have been supported hitherto comprise: (i) a project concerning the factory health service; (ii) attendance on a course in research method; (iii) the psychosocial support provided during and after pregnancy and delivery; (iv) communicative problems before and after laryngectomy; and (v) an investigation of children's and parents' situation during a child's committal to hospital.

26. **Nursing shortages in NHS hospitals.** *British Medical Journal*, London, 1978, July 15, vol. ii, pp. 222-223.

Apart from lack of finance and difficulty in recruiting, nursing shortages are caused by: (i) lack of criteria for calculating nursing establishments; (ii) overdependence on students; and (iii) a lack of planned allocations down to ward level. From 1949 to 1974 the number of registered nurses grew by 82 per cent, while the proportion of auxiliaries grew by 224 per cent. Shorter hospital stays mean that more intensive nursing is required and technological advances call for more specialized nursing skills. These requirements represent areas where the shortages are most severe. Some attempts have been made to plan post-basic training nationally by the Joint Board for Clinical Nursing Studies, but few nurses have completed the courses. The Briggs report has remained unimplemented for five years. Neither the will nor the finance is available to deal effectively with nursing shortages.

27. BEVIS, E. O. **Curriculum building in nursing: a process.** 2nd edition. St. Louis, C. V. Mosby, 1978, xi, 242pp. £7.60

The aim of this book is to provide a source of information for those involved in the process of nursing curriculum formation, revision or study. There are eight chapters on: the nature of nursing: common frame of reference; the philosophical basis of nursing; the setting of the conceptual framework of nursing; the student; the theory of nursing; the course patterns; learning strategies; and the organization and evaluation of change.

28. LYNDRUP, I. Sygeplejersken i klemme: uddannelseskapaciteten må øges før flere får halv sygeplejerskeuddannelse. **[The need for increased training capacity for nurses to prevent encroachment on what has up to now been their sphere of work by other professionals.]** *Sygeplejersken*, København, 1978, July 26, no. 29, pp. 10-11, 15.

To justify the establishment of the many new para-nursing categories (auxiliary nurse, old peoples' home assistant, medical secretary etc.) the employer's side points to the shortage of nurses. Yet, at the same time there are 1,000 qualified applicants for the 60 places at one school of nursing, 289 applicants for the 22 places at another, and so on throughout the country. There is a strong suspicion that the employer's side is maintaining an artificial shortage of nurses in order to be able to economize by filling the vacant places with members of less well qualified groups. This must result in a reduction in the standard of patient care, and competition between staff organizations, leading to under-bidding round the pay talks table. Nurses are thus engaged in training auxiliaries who will then compete with them for their jobs at less pay. Nurses in positions of authority must draw the line and refuse to contribute to a further reduction in nursing standards instead of playing the administration's game and agreeing to such reductions in the name of economy. Courses of further training must be organized as *nursing* courses, not as diluted medical student courses, and passing them must result in worthwhile pay increases. The country must establish a national academy of nursing, with room for all qualified applicants.

29. NARDOZZI, L. and SABATTINI, P. La figura dell'assistente sanitario in ospedale. **[The role of the health assistant in hospital.]** *Ospedale*, Torino, 1978, July, vol. 31, no. 7, pp. 175-178.

The health assistant, defined in Italy in 1974 as a professional person who operates

in the field of public medicine, to some extent replaces the health visitor who was particularly concerned with public hygiene, the school medical services, clinics for 'social' diseases, and TB dispensaries. The author examines what the duties of this health assistant might be in the hospital. He suggests that he/she might be concerned with preventive medicine in relation to hospital staff (vaccinations, epidemiological surveys, health checks for catering staff, the recording of reports of infectious diseases, checks on persons exposed to ionizing radiation, health statistics), the supervision of disinfection and disinfestation operations, environmental hygiene, contact with ex-patients, in particular the old, the handicapped, and the chronic sick, the reception of patients in the emergency and first aid departments, and preventive medicine in other departments.

30. GWYNNE, A. L. **The legal importance of nursing notes.** *Nursing Times*, London, 1978, July 13, vol. 74, no. 28, pp. 1161, 1162.

Nursing notes may be invaluable in refuting an allegation and, since the interval between clinical and legal events may be as long as 15 years, the necessity for their retention is obvious. Meticulous record keeping is particularly important in group practices and health centres, where several members of a team may attend one patient. It is important that the results of investigations are not filed away until they have been initialled by the doctor. Notes should be legible and accurate and should include the dates and times of entries.

31. BROWN, B. J. **Politics and power.** *Nursing Administration Quarterly*, Germantown, Md., 1978, vol. 2, no. 3, pp. 1-103.

Politics is essential in the nursing profession for affecting policy changes involving both staff nurses and health care planning at local, state and national levels. Nurses need to plan and form strategies together in order to accomplish change. The papers in this special issue show the commitment of nurses to change. They are on: (i) political nursing - essential for health service and education systems of tomorrow; (ii) nursing goals in health care; (iii) role consensus and group consensus; (iv) legislation affects nursing practice; (v) communication and influence in nursing; (vi) assertiveness training for nurses; (vii) legislative and licensing problems in health care; (viii) the Equal Rights Amendment—the chance for equality; (ix) the acquisition and use of power in academia; and (x) nursing involvement in national health insurance.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See Abstract No. 29

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 7, 59, 99, 110, 122, 127, 130, 147

32. DEABLER, L.-R. **Shared services in a small multihospital system.** *Hospital Progress*, St. Louis, 1978, May, vol. 59, no. 5, pp. 64-65, 92.

This article describes the experience of a multi-hospital organization, the Tri-County

Hospital Group, Wooster, Ohio, in dealing with the problems and benefits encountered when three hospitals combine to produce more economical care. The primary shared services include the following: (i) laundry and linen service; (ii) centralized purchasing; (iii) data processing, including medical records; (iv) pharmacy; and (v) in-service training. Charges for supplies are based on the cost to the base hospital, which is the largest of the three hospitals involved. Each departmental head at the base hospital plans and budgets for each of the hospitals, in conjunction with the administrator of each of the smaller hospitals. Tri-County hopes to enlarge the system and is preparing for the improvements in communication which will become necessary. Multi-hospital sharing systems have a better chance of surviving under pressure of government regulations than the independent hospital.

33. GRIGG, T. C. **Hospitals—the hub of health.** *New Zealand Hospital*, Wellington, 1978, May, vol. 30, no. 4, pp. 1, 3.

The New Zealand hospital service spent about 600 million dollars of the 823 million spent on health services for the year 1977 to 1978. The hospital service is often accused of spending large sums on specialties such as cardiac and neurosurgery, but many of the procedures involved subsequently become standard, the staff employed in such units become leaders in their field and those treated are able to return to a productive life. In addition, the hospital service has an important teaching role to play and high standards must be maintained. The successful extension of health care into the community is also dependent on the quality of service provided by the hospitals.

34. SACKS, T. J. **It takes a sense of survival.** *Hospitals*, Chicago, 1978, April 16, vol. 52, no. 8, pp. 101-102.

There is a legitimate role for the small urban hospital. In order to perform that role optimally, however, the small hospital must select the services that it provides carefully, avoiding those that are better suited to larger institutions, and must investigate the appropriateness of sharing services with other small hospitals. Forkosh Memorial Hospital, Chicago, is such a hospital. It has continued to operate by: (i) eliminating unnecessary services (obstetrics is a prime example); (ii) eliminating services requiring a high volume; (iii) participation in areawide health planning; (iv) attracting paying patients; and (v) adopting cost-sharing programmes.

35. HOEFNAGELS, K. Regionalisatie mist landelijk programma. **[Regional planning in the Dutch national health/hospital services programme.]** *Ziekenhuis*, Utrecht, 1978, Aug. 2, vol. 8, no. 15, pp. 394-399.

Health services regionalization in the Netherlands suffers from a lack of national co-ordination and philosophy. In planning a new system three inter-related aspects should be taken into account; functional, financial and administrative. The present administration allows free movement between the national and municipal level pending the creation of new provincial areas, whilst financial arrangements are covered by the number of members of the insurance companies varying from some 5,000 to 650,000, and the functional provisions range from home helps to large hospital services. The services are divided into four main eschelons: public health care; general practitioners and district care; specialist curative care; and nursing care and rehabilitation. They vary in scale from care for 50,000 to one million inhabitants. To plan a better

co-ordinated system two principal guidelines should be observed: (a) development should be carried out within the framework of the administrative, financial and functional aspects; and (b) work should be within a scale which can accommodate and co-ordinate these aspects. Comprehensive health care areas of similar size should be created which form part of one national system. This will mean a more even distribution of first class medical and teaching hospitals. Such areas could roughly correspond with the provinces which, already having an administrative structure and being democratically elected, would form a good starting base.

36. WESTLEY, M. W. and WESTLEY, W. A. Organisation hospitalière et qualité de la vie au travail. **[Hospital organization and the quality of life at work.]** *Administration Hospitalière et Sociale*, Montreal, 1978, May/June, vol. 24, no. 3, pp. 18-19, 22-25.

The authors discuss the various factors which impede integration and co-ordination in the organization of the modern hospital. They describe a method of socio-technical analysis, developed at the Tavistock Institute in London, which can be used to determine what organizational changes are required and how they may be implemented.

GOVERNING BODIES, COMMITTEES

See Abstract No. 22

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 10, 13, 48, 49, 103

37. BRADLEY, J. A. and JANCO, J. W. **Professional energy audit points way to $100,000 annual saving.** *Hospital Progress*, St. Louis, 1978, June, vol. 59, no. 6, pp. 70-74.

St. Mary's Hospital, Troy, New York, had a professional energy audit conducted of the hospital's physical plant as part of an overall plan to reduce expenses. Certain energy saving features had already been installed. The consultants from the Hospital Association of New York State made a number of detailed energy saving recomendations accompanied by cost benefit analyses. The majority concerned heating systems, including: (i) automation of the boiler plant; (ii) installation of a heat exchanger for reclaiming boiler heat; and (iii) a more economical use of the air-conditioning system. It was estimated that the implementation of all the recommendations would result in a saving of $100,000 per year, 35 per cent of which could be realized without any capital expenditure. Those involving expenditure are to be spread over a number of financial years.

38. OLOWOKURE, T. O. **Cost comparison and efficiency among acute hospitals in England and Wales.** *Public Finance and Accountancy*, London, 1978, Aug., pp. 433-439.

Current methods of comparing hospital costs assume that the lower the unit cost the greater its efficiency. This may solve the accounting problems of inter-unit cost

comparison, but it ignores or under-rates the existence of other problems such as differences in the operation of the accounting system in each hospital, and the input and output of each hospital which make it impossible to say that lower unit costs equal greater efficiency. The purpose of this paper is to throw light on the influence of a variety of factors on hospital costs in the hope that inter-hospital cost comparison will be made more meaningful. The investigation is restricted to input and output factors and assumes that differences in the operation of the accounting system are not significant enough to affect comparability of costs. The analysis is based on the data of type I acute non-teaching hospitals in England and Wales for the financial year 1967/68. The results show that differences in efficiency between hospitals are caused by variations in patient mix, throughput, rates of use of facilities, state of technology, location, size, and local authority welfare expenditure. While the findings are valid for the hospital and the size and occupancy range studied, the majority of the significant variables are capable of explaining substantial variations in the costs of other general hospitals.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 102, 104, 123, 131, 132

39. WEST, R. **Bed usage and disease specific mortality within ICD chapters.** *Journal of Epidemiology and Community Health*, London, 1978, March, vol. 32, no. 1, pp. 38-40.

Using Hospital In-Patient Enquiry (HIPE) data the relationship between mortality and bed use was examined for a number of disease categories within 10 chapters of the International Classification of Diseases (ICD) by the World Health Organization. The significant level of correlation between bed use and mortality found to exist for the disease categories within Chapters II, VI, VII, VIII and XIII of the ICD tends to support the use of standardized mortality ratios (SMR) for these groups. However, it is suggested that separate SMRs for urinary disease and genital disease should be used and that the SMRs for chapter XVII (accidents, poisoning, and violence) should be either omitted from the formula or calculated for separate subdivisions of the chapter.

40. MCCOLL, I. **Caring for the acutely ill—a surgical look at length of stay in hospital.** *Health and Hygiene*, London, 1978, April/June, vol. 1, no. 4, pp. 179-180.

The key to finding the right length of stay in hospital for various types of surgery may lie in a more detailed assessment of the patient prior to admission. Day care surgery is often favoured, especially for children and minor operations, but it only reduces costs if the reduction of the length of stay is matched by a reduction of wards and hospitals. To make short-stay care cheaper, the centre of activity would have to move from the wards to an out-patient department equipped with first class facilities. Admitting an increased number of major cases and reducing lengths of stay increases the workload on staff, and quality of care may deteriorate. Some type of audit is needed to measure the quality of care and help hospital staff maintain standards in the face of the demand for more results.

ELECTRONIC DATA PROCESSING

See Abstract Nos. 44, 95, 100, 127

LIBRARIES

41. LIBRARY ASSOCIATION. MEDICAL SECTION. **Books and periodicals for medical libraries in hospitals.** 5th edition. London, Library Association, 1978, 79pp. £2.00

The subject scope of this fifth edition has been extended to areas which are not strictly medical in order to increase the value of the lists to multidisciplinary libraries. These are in two sections: books, arranged alphabetically by subject headings; and periodicals, following the same arrangement. The items recommended are those within the purchasing capacity of a small medical library, and consequently some of the larger standard works which appeared in earlier editions have been omitted as their price is now too high. In addition a list of medical booksellers, periodical agents and subscription libraries has been included.

MEDICAL RECORDS

See also Abstract Nos. 30, 100

42. HOLDICH, R. J. **The importance of patient care records.** *Nursing Times*, London, 1978, July 13, vol. 74, no. 28, pp. 1159-1160.

Medical records may be used in: (i) providing optimum care; (ii) training nursing and medical students; (iii) clinical research; (iv) medico-legal cases; and (v) planning. The centralized storing of the unit medical record has led to the present complexity of hospital medical record departments. A new format has been provided in recent years by the appearance of the problem-oriented medical record, an approach of particular interest to the nursing staff. Many hospitals are putting their medical record index on to a computer. On the question of confidentiality of records, it must be remembered that patient's records do not belong to them and may, with appropriate care, be communicated by the medical staff for the benefit of both the patient in question and others with a similar medical problem.

43. WILSON, L. A. and others. **The new Aberdeen medical record.** *British Medical Journal*, London, 1978, Aug. 5, vol. ii, pp. 414-415.

In the medical record system at the Aberdeen Hospitals Group all 'like' documents are grouped together in four sections: (i) correspondence; (ii) written case records; (iii) investigation reports; and (iv) miscellaneous. The method of filing each group of documents is described. The case record folder is colour-coded to identify misfilings and a space on the folder is used to print filing instructions. The practices used in editing the four types of documents are described: no papers are destroyed before 15 years has elapsed after the last contact with the patient, or six years after the patient's death. Both clinicians and staff in the medical records department have benefitted from the new system and developments such as producing summaries and a master patient index for the area are progressing well.

44. GELDEREN, C. L. van. Automatische informatie-verwerking in de gezondheitszorg. **[Automatic information processing in the Dutch health (hospital) service.]** *Ziekenhuis*, Utrecht, 1978, July 19, vol. 8, no. 14, pp. 368-370.

The increasing complexity of medicine and the general increases in costs point to

the need for more automation in information processing. The current argument is to decide how far this should apply to individual hospitals and how far this should be a regional or national development. Experience shows that in large and medium size hospitals the introduction of a computer system is economically and financially justified. This will eventually be a medical decision, promoting co-operation and data exchange between hospitals with support from general funds if required. This also means that small hospitals who cannot afford computer systems of their own can still co-operate with larger hospitals including having access to data banks. Suppliers of computer systems (Honeywell Bull supply nearly half the Dutch market) have to keep abreast of the latest technical developments and remain flexible in their approach. They study the organization and requirements of individual hospitals, the number and type of regional participating organizations, priorities, etc. Cost conscious automation has led to development in phases as hospitals, in addition to automation of their financial administration (patient administration, accounts, etc.), gradually introduce non-administrative functions (appointments, staff rotas, etc.). Consumer consultation, taking place every three months, has resulted in joint programme building and discussions in various fields (such as accounts, salary administration, hospital pharmacies).

45. FARNDALE, W. A. J. **The law relating to medical records.** *Nursing Times*, London, 1978, July 13, vol. 74, no. 28, pp. 1163-1164.

Although in general no information from a patient's record may be given by a hospital without the patient's consent, there are occasions when disclosures can be compelled by law. These include: (i) when a member of the hospital staff is a compulsory witness on a *subpoena*; (ii) when information is required by statute, for example, notification of infectious diseases; (iii) when criminal injury is suspected; and (iv) when the police require identification of a driver alleged to be guilty of a motoring offence. A new House of Lords ruling allows disclosure to a patient's legal advisers rather than just to his medical advisers, a decision likely to be unpopular with medical and nursing staff in hospitals and which will doubtless be approached with discretion by the courts.

HOSPITAL STATISTICS

See Abstract No. 79

PUBLIC RELATIONS

See Abstract No. 84

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 21, 30, 45

46. OSTHEIMER, N. C. and OSTHEIMER, J. M. **Life or death—who controls?** New York, Springer, 1976, x, 308pp.

The papers in this anthology are linked by a single theme: the need to make certain social and, ultimately, political decisions on issues of life and death. The book is

divided into four sections: (i) eugenics: social choice or nature's way; (ii) abortion on demand; (iii) compulsory sterilization: population control; and (iv) how to die: euthanasia. The 23 papers are followed by an epilogue which considers current public attitudes on life and death. Bibliographies are included after several of the papers; there is also a list of selected readings on topics covered by each of the four sections (pp. 299-302).

OTHER SPECIAL ASPECTS: COMMISSIONING

See Abstract No. 8

FINANCE AND ACCOUNTING

FINANCE

See also Abstract Nos. 38, 101, 127

47. McDaniel, J. P. **We have seen rate review, and it works.** *Hospitals*, Chicago, 1978, April 16, vol. 52, no. 8, pp. 71-73.

Maryland has had a rate regulation law since 1971 and the state's Health Services Cost Review Commission (HSCRC) has been establishing rates since 1974. The state hospital association itself sponsored the legislation and continues to support it. Each hospital must now submit an annual budget to the HSCRC 90 days after the beginning of each fiscal year. All financial aspects of the hospital's operations are presented in detail in a format based on allowable costs during the previous fiscal year. Also required are annual audited financial statements, volume reports and requests for rate revisions if they become necessary. After a 'desk and site' review of the budget and corresponding rates, the HSCRC staff recommends to the seven-man commission that the rate be either approved or denied, in whole or in part, using the 80th percentile rule in most areas. Although there was friction in the beginning between HSCRC and health care providers, the latter, with strong encouragement from their associations, played an important role in adopting a constructive programme.

48. Branson, R. M. **Informed, involved employees aid hospital's cost control program.** *Hospitals*, Chicago, 1978, July 1, vol. 52, no. 13, pp. 75, 76, 78.

In September 1976 the 236-bed South Community Hospital, Oklahoma City, initiated a two-part programme for cost containment which emphasized staff responsibilities and participation. The first part presented the American Hospital Association programme *Cost containment through operations management* to department heads in five two-hour sessions. In the second part of the programme, a cost containment scheme was established to implement the concepts and techniques of cost containment presented in the first part. The committee included various department managers and other interested and qualified staff Up to January 1978 the hospital saved $148,200 through its cost containment efforts. Examples are given of the means by which this was achieved.

49. Peterson, R. R. **Cost improvement program generates major savings.** *Hospitals*, Chicago, 1978, July 1, vol. 52, no. 13, pp. 83, 84, 86, 88-90.

In August 1975 Johns Hopkins Hospital, Baltimore, initiated a formal cost

improvement programme by establishing four cross-functional pilot teams of hospital staff. Since its inception, it has become a major institutional programme resulting in over 200 cost improvement projects. Moreover, a model has evolved for an ongoing, multifaceted approach to cost containment that is designed to involve directly a broad range of staff. The programme is based on the cross-functional teams of eight to 12 members most of whom are supervisory, paraprofessional or technical staff. The mode of operation of the teams is described. Other features of the programme include annual goal-setting by each functional unit, cost awareness education and incentives.

50. FEDER, J. M. **Medicare: the politics of federal hospital insurance.** Lexington, Mass., Lexington Books, 1977, ix, 177pp. £11.50

The fundamental premise of this book is that Medicare policy towards hospitals has been profoundly influenced by the perspectives and goals its administrators acquired in a social insurance agency which emphasized efficient claims payment rather than controlling the impact of payment on the costs and quality of medical care. There are seven chapters which consider: alternative strategies for Medicare's implementation; the development and implementation of conditions for participation; professional peer review; Social Security Administration and the practice of medicine; paying the hospitals; the development of principles of hospital reimbursement and maintaining the bargain; containing hospital costs; political peace and bureaucratic control; Medicare; and the politics of federal hospital insurance. A selected bibliography is included (pp. 159-168).

51. BROMBERG, R. S. and TRULY, E. **Tax and Medicare aspects of hospital malpractice insurance (part 1).** *Hospitals*, Chicago, 1978, April 16, vol. 52, no. 8, pp. 67-70.

Until recently hospitals in the United States obtained adequate liability coverage from commercial insurance carriers. Today, however, cost-conscious hospitals can no longer afford to follow this simplistic approach and are seeking alternatives. This first part of a two-part paper on how tax laws and Medicare regulations affect hospital malpractice insurance discusses self-insurance mechanisms, particularly trust funds. Medicare and other intermediaries' reimbursements, investment income from such funds, and payments to and from the funds are examined.

52. MECHANIC, D. **Considerations in the design of mental health benefits under National Health Insurance.** *American Journal of Public Health*, Washington, 1978, May, vol. 68, no. 5, pp. 482-488.

The existing insurance for mental health benefits provides incentives for hospital as compared with community care and reinforces a medical approach to psychological disability. The structure of benefits favours the author and provides help for the integration of the chronic psychiatric patient into the community. It is suggested that under National Health Insurance there should be a mental health resource development fund intended for building a stronger network of community mental care. The pattern of benefits should be consistent with developing psychiatric services on a capitation basis.

HOSPITAL ACCOUNTING

See Abstract No. 147

SUPPLIES AND STORES

SUPPLIES

53. GORDON, D. **Salmon: will it sink or swim?** *Health and Social Service Journal*, London, 1978, July 7, vol. 88, no. 4698, pp. 754-755.

The report of the Supply Board Working Group (Chairman: Brian Salmon) recommends more centralization of storage and purchasing of supplies within the National Health Service. However, the lack of a firm directive from the Department of Health and Social Security on this topic means that individual authorities will not feel obliged to follow the report's advice. The study team recommends more efficient supplies information and the setting up of a supply council to issue directives. Twenty-one other recommendations made by the Supply Board Working Group, making up a comprehensive plan for the organization of supply work, are listed.

54. MASINI, R. Ospedali e riforma: il ruolo e le competenze dell'economo-provveditore. **[Hospitals and reform: the role and the competence of the supplies manager.]** *Tecnica & Metodologia Economale*, Firenze, 1978, July/Aug., vol. 17, no. 4, pp. 216-218.

Within the context of the proposed re-organization of the health service in Italy and the establishment of local health units the author examines the role of the bursar-supplies manager. He suggests that initially there should be a regional supplies manager, and supplies managers and bursars attached to one or several units. Eventually the two functions should be merged and a regional training school established for those intending to make a career in this sector of the health service.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

55. MONTENERO, P. Compiti e mansioni del servizio di dietetica in ospedale. **[Tasks and organization of the dietetic service in hospital.]** *Tecnica & Metodologia Economale*, Firenze, 1978, May/June, vol. 17, no. 3, pp. 162-164.

An effective hospital dietology department will require the services of at least one medically qualified dietologist, several medically qualified nutritionists, and at least four dietitians. The author lists the duties of the dietologist: these include supervision of the equipment and systems used in the catering department; sampling for food tests and checks; supervision of the activity of the dietitians; and providing up-to-date information for the catering staff. The duties of the dietitians will cover the hospital kitchens, the wards, the dietetics laboratory, and the dispensing of food.

56. POT, H. J. A. Grootkeuken van de toekomst, IV: handponsmenukaarten voor snelle verwerking van administratie rond keuze menu. **[Kitchens of the future, IV: a manual menu punched card system to speed up menu choice organization.]** *Voeding-en Huishoudgids*, Amsterdam, 1978, May 29, vol. 45, no. 546, pp. 287, 289, 291.

Data regarding patients' records, computer processing and reading for distribution

are entered on the punched cards by hand in a system of numbers, codes, press-through perforations and colour codes. The computer produces total lists which may refer to kitchen, ingredients, quantities, planning, staff, equipment, etc. A typing and counting device is attached to the computer for manual alterations on the lists. Organization of a new food administration system requires attention to: (a) choice of diets, menu cycle and interchangeability of components; (b) listing of diets, role of dietitian, kitchen and ultimate control; (c) numbers of staff and their specific role; (d) purchasing of food; (e) storage; (f) means of transport and distribution; (g) equipment; (h) timing and planning; (i) transport routes and food issue. A suggestion is given on how to design a card, using the back of a Dutch giro card, one for each meal, with vertical markings and numbers totalling up to 92 medium size or 55 large size figures. Accessories to the system are mentioned, such as computer reading cards, tipped pens, storage containers, wall card holders with compartments, etc. A small computer can produce all the data for a 500-bed hospital in 20 minutes. The paper includes two photographs and two examples of menu cards (German) which do not correspond with the design suggestions.

DIETETICS IN THE HOSPITAL

57. RENZULLI, L. and RENZULLI, G. Struttura e management sanitario del servizio ospedaliero di dietetica. **[Structure and hygiene management of the hospital dietetic service.]** *Tecnica & Metodologia Economale*, Firenze, 1978, July/Aug., vol. 17, no. 4, pp. 201-202, 204-207.

The dietetics department in hospitals has grown from a small optional unit employing only paramedical staff to a divisional-type unit with a medically qualified specialist dietiticion at its head. The author examines the somewhat piecemeal Italian legislation relating to the dietetics department and suggests that the regional authorities should now define a proper organizational structure for this department.

58. WARNOLD, I. and others. **Energy intake and expenditure in selected groups of hospital patients.** *American Journal of Clinical Nutrition*, Bethesda, 1978, May, vol. 31, no. 5, pp. 742-749.

In order to determine the daily energy needs that can be expected for hospitalized patients and to define patients at risk from an inadequate supply, 70 patients from five selected groups of patients were studied. Sixty-seven had various medical diseases or were undergoing orthopaedic rehabilitation and were studied for a total of 177 days. The remaining three patients were admitted to hospital for severe burns and studied for a total of 303 days. The data presented show that the energy intake of patients varies greatly. The intake of the debilitated and inactive patients was not higher in men than in women, in spite of a higher energy expenditure, which indicates that the appetite was reduced due to the disease. The low energy intake of patients who needed assistance in eating supports the impression that reduced appetite was not the only factor limiting their food intake. The results reveal that elderly, debilitated patients as well as active patients admitted to hospital for medical observation or control, received an inadequate energy supply.

KITCHENS

59. VEEN, K. ten. Uniek initiatief van chef-kok: bewoners van De Boomberg te Hilversum krijgen voorlichting over maaltijden. Resultaat: groeiend begrip voor werk keukenpersoneel. **[The chef's unique initiative in informing the residents in the De Boomberg old people's home, Hilversum, about meal preparation has given them a growing understanding of the work of the kitchen staff.]** *Voeding-en Huishoudgids*, Amsterdam, 1978, May 29, vol. 45, no. 546, pp. 275, 277, 279.

The chef, Mr. ten Veen, began a series of meetings last year in which he addressed 20 residents at a time on the work in the kitchen. From a lukewarm reception at first the meetings have now become popular and created understanding and appreciation of kitchen problems among the residents. After a brief description of his own training he lists 28 tasks he has to carry out with regards to cooking, working out menus, ordering and checking, special diets, cleaning of crockery, kitchen and equipment, budgeting, management of kitchen staff, working rotas, pupil training, purchasing, store management and his responsibility to hospital management. He names the grades of kitchen staff and the hours they work. He talks of some complications which can occur when catering for 128 residents, 81 of whom have special diets. He mentions the general requirements for proteins, vitamins, minerals, calories and variety, and factors to be taken into account when working out the menus, i.e. nutritional values, colour combinations, flavour, seasonal products, practical execution, day of the week, time, basic foods, costs. Finally he points out that hospital cooking always carries some restrictions and that one cannot always please everybody. The paper includes a photograph of his 28 tasks-list.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

60. GUERCILENA, A. I germicidi da sali di ammonio quaternario in lavanderia. **[Germicides from the salts of quaternary ammonia in the laundry.]** *Tecnica & Metodologia Economale*, Firenze, 1978, July/Aug., vol. 17, no. 4, pp. 227-233.

Laboratory tests have shown that laundry which is disinfected with a quaternary ammonia compound retains its bacteriostatic power for a period after treatment so long as the material is dry. The author recommends the use of Braxene, in the proportion of 500-600 grammes per 100 kilogrammes of laundry for the first few treatments, after which the quantity of Braxene can be halved. He adds that no disinfectant can ever be as effective as heat sterilization.

HOSPITAL LINEN AND TEXTILES

See also Abstract Nos. 73, 74

61. GABRIEL, S. **RFH—the first line of defence.** *Power Laundry & Cleaning News*, London, 1978, Aug. 4/18, pp. 13, 15-17, 21.

Reduced fire hazard (RFH) fabrics are the first line of defence in preventing ignition

of hospital textiles. Having provided RFH fabrics it is essential that they are laundered and finished to a definitive wash/finish programme so that they remain safe fabrics. The types of RFH fabrics currently available are briefly discussed and advice on laundering is given.

62. BELKIN, N. L. **Role of textiles in isolation areas.** *Hospital Topics*, Sarasota, 1978, March/April, vol. 56, no. 2, pp. 13-14, 16.

The author argues that disposable gowns and bed linen are not necessarily best in isolation areas, both on grounds of cost and infection control. Re-usable gowns of suitable material, designed without tie and belt closures, are less expensive in terms of 'cost-per-use'. Stains on re-usable bed linen can be removed by a suitable laundering process. The use of materials combining man-made and natural fibres will produce a fabric which will provide comfort for the patient while keeping the shedding of lint to an acceptable level. There is no conclusive evidence that disposables cost less as many factors, such as the cost of storage and disposal, have to be considered.

HOSPITAL DOMESTIC MANAGEMENT

63. ASSOCIATION OF DOMESTIC MANAGEMENT. **Report of the Annual Conference 1978, Garnett College, Roehampton.** Ashford, Kent, Association of Domestic Management, 1978, 16pp.

This report outlines the papers presented at the 1978 Annual Conference. The six papers consider: the medical requirements for the control of infection; the nursing requirements; medical screening of staff; infestation in health service buildings; special cleaning requirements in operating theatres, intensive care, renal units and computer rooms; and the role of a regional domestic services officer.

HYGIENE IN THE HOSPITAL

HOSPITAL INFECTIONS

64. COWEN, J. and others. **Group B streptococcal infection in a maternity unit.** *British Journal of Obstetrics and Gynaecology*, London, 1978, July, vol. 85, no. 7, pp. 541-545.

Neonatal infection due to Group B streptococci is described in the maternity unit of Northwick Park Hospital, Harrow, Middlesex. Six babies were affected between September 1976 and April 1977 and two of these babies died. The babies had septicaemia with positive blood culture or high clinical suspicion of Group B streptococcal infection with isolation of the organism from several surface sites. The same organism was isolated from the mother's vagina. Three of the babies were born at term and weighed more than 2.5 kg. Tachypnoea was the earliest clinical sign in each case and it is recommended that newborn infants with persistent tachypnoea and evidence of maternal or infant colonization with Group B streptococci should receive antibiotics. Alternative approaches to the diagnosis and management of infection with Group B streptococci are discussed and rejected.

PREVENTION AND CONTROL

See also Abstract Nos. 60, 62, 74, 75

65. PFANZELT, R. and SCHASSAN, H.-H. Krankenhaushygienische Umbebungsuntersuchungen einschliesslich Kontrolle der Desinfektionsmassnahmen in zwei operativen Kliniken. **[Investigation into the hygiene standards and control of disinfection in two hospitals.]** *Zentralblatt für Bakteriologie, Parasitenkunde, Infektionskrankheiten und Hygiene*, 1 Abt., Orig. B, Stuttgart, 1978, Aug., vol. 167, nos. 1/2, pp. 22-28.

The standard of hygiene in the operating suites of two different hospitals was tested. Hospital A, opened in 1960, has only a staff air-lock using an undivided ante-room which serves as changing room (no locks for materials or patients), has windows which open, and air intake via a terminal C filter. Hospital B is a new building with a full air-lock system, air-conditioning with S class Hosch filters, and ultraviolet installations above the doors. In hospital B the reactive frequency of demonstrable bacteria was 55 per cent; in hospital A the figure was 80 per cent. Among non-pathogenic bacteria DNase-negative staphylococci preponderated. *Clostridium* perfringens was used as an indicator of invasion routes: the most important being non-airtight windows, air-conditioning plant and deficient air-locks. The efficacy of disinfection varied between 67 and 100 per cent. The results show that sterility cannot be attained in general operating suites. They also show however that a satisfactory standard of hygiene is not possible without a proper air-lock system and efficient air-conditioning.

66. PFEIFFER, E. H. and others. Hygienisch-bakteriologische Vergleichsuntersuchungen an 50 Krankenhäusern. V. Keimzahlen auf Flächen in Krankenhäusern. **[Hygienic and bacteriological studies in 50 hospitals. V. Bacterial contamination of hospital surfaces.]** *Zentralblatt für Bakteriologie, Parasitenkunde, Infektionskrankheiten und Hygiene*, 1 Abt., Orig. B, Stuttgart, 1978, Aug., vol. 167, nos. 1/2, pp. 11-21.

Extensive tests were carried out in 50 hospitals with the aim of assessing the extent of contamination of surfaces with micro-organisms. A total of 7,951 samples were taken; each from a surface of 21 sq.cm. Twenty per cent of the cultures showed contamination exceeding 300 colonies per 21 sq.cm.; the mean value for all samples with less than 300 colonies was 58. The figures for specific areas were as follows: operating suites, delivery rooms and premature baby units—average 30 colonies per 21 sq.cm.; 30 per cent had less than 10 colonies and five per cent more than 300; intensive care units, newborn infant units and children's wards—average 50 colonies per 21 sq.cm.; surgical, medical and gynaecology wards—average 60 colonies per 21 sq.cm., with 15 per cent less than 10 colonies and 10 per cent more than 300.

67. Sjukhushygien på operationsavdelningar. **[Hospital hygiene in the operating suite.]** *Sjukhuset*, Göteborg, 1978, vol. 55, no. 5, pp. 407-412.

The six groups reporting at the seminar discussed: (i) staff dress in theatre; (ii) pre-operative preparation of the patient; (iii) transport of patient to and from theatre; (iv) anaesthetic staff and materials; (v) differentiated hygiene routines for different categories of patient; and (vi) modern central operating theatres. Theatre staff and any visitors, technicians, etc., must change into and out of the clothing required by the

surgeon, including protective shoes (not rubber boots, because of the air-pump effect). Staff should have a shower the night before or at the latest three or four hours before the operation, not immediately beforehand. Ultraviolet light (USA-64) halves the quantity of airborne bacteria. The patient must be washed, shaved and have the skin disinfected prior to operation. Transport of the various categories of patient through the air-locks to and from theatre must be planned with the aim of reducing infection. Floors should be semi-conducting, to carry away static electric charges. The number of staff attending operations and moving about theatre has tripled since 1952 without any increase in the number of operations. Staff entering and leaving theatre must follow the full current disinfection routine. Cupboards with stores of common medicaments should be available to reduce the need to leave theatre for supplies. All anaesthetic apparatus must be maintained scrupulously sterile. Patients should be categorized by the degree of hygiene required at the operation. The use of a special operating theatre for highly contaminated cases is only needed in a hospital with a heavy (continual) case load. Modern central departments of surgery may have up to 25 operating theatres, each with preparation room and recovery room, and a basic staff of over 100. Provided staff can be found and a properly designed building is available, these arrangements work very satisfactorily: fewer anaesthetists are needed, and specialists are always at hand in emergencies.

68. HINGST, V. Zur Bedeutung von Trockenfussmatten für die Verminderung der Keimverschleppung im Krankenhaus. **[The importance of adhesive dry mats in the reduction of germ spreading in hospitals.]** *Zentralblatt für Bakteriologie, Parasitenkunde, Infektionskrankheiten und Hygiene*, 1 Abt., Orig. B., Stuttgart, 1978, Aug., vol. 167, nos. 1/2, pp. 83-86.

Mats of man-made fibre or rayon, impregnated with disinfectant, are not effective in reducing the number of micro-organisms on the footwear of hospital staff. Tests with antimicrobial adhesive mats show that they reduce the number of micro-organisms on the soles of clean shoes by 50 per cent and kill the micro-organisms by means of the disinfectant with which they are impregnated. Adhesive capacity reduces rapidly with soiled shoes and the adhesive mats should therefore be used only in areas where a high degree of cleanliness is essential.

69. KOLLER, W., ROTTER, M. and KUNDI, M. Wertbestimmung von Verfahren für die Hygienische Händedesinfektion: Vergleich zweier Kontaminationsmethoden und Verwendung eines automatischen Kolonienzählgerätes. **[Evaluation of procedures for hygienic disinfection of hands: comparison of two methods for artificially contaminating hands and the use of an automatic colony-counter.]** *Zentralblatt für Bakteriologie, Parasitenkunde, Infektionskrankheiten und Hygiene*, 1 Abt., Orig. B., Stuttgart, 1978, Aug., vol. 167, nos. 1/2, pp. 38-47.

Two methods of testing the efficiency of hand disinfection are compared. In method 1 a bacterial suspension is dropped on to the finger tips: in method 2 the hands are immersed in a bouillon culture of *Escherichia coli*. It is recommended that method 2 be given the preference since higher values are obtained and this gives a wider range for measuring the reduction factor. Automated colony counting saves much time but this technique cannot distinguish between colonies of test bacteria and those of normal skin flora.

70. MORO, S. and SECRETO, R. Criteri di indirizzo per la disinfezione in ospedale. **[Criteria for guidelines for hospital sterilization.]** *Ospedale*, Torino, 1978, July, vol. 31, no. 7, pp. 179-192.

A detailed analysis is presented of the factors to be considered when choosing a range of disinfectants for hospital use. These factors include the concentration, stability, and pH of the disinfectant solution, the microbial populations present, the material to be disinfected, compatibility of the disinfectant with the substrate, i.e. soap, detergents, and the absence of injury to the material. The author suggests that chemical disinfectants should only be used when heat treatment is not possible; that, when disinfected material is to be re-used the disinfectant should not cause rapid and serious deterioration; and that the choice of disinfectant should be based on the effectiveness of the active ingredient, the maintenance of this effectiveness in use, the cost, ease of use, and residual activity. The number of disinfectants used should be restricted in order to avoid confusion; staff should be properly trained in their use; and any disinfecting which can be centralized should be centralized.

71. BREEN, K. J., WHELAN, G. and SMALLWOOD, R. **Viral hepatitis in general hospitals: guidelines for control and prevention.** *Medical Journal of Australia*, Glebe, 1978, July 1, vol. 12, no. 1, pp. 18, 20, 22, 24.

This paper reviews current knowledge of viral hepatitis A and B, considers the risk to patients and staff posed by the presence of hepatitis sufferers in general hospitals and suggests guidelines for hepatitis prevention and control. The hospital should adopt a simple approach to control including education of staff in the safe care of patients known to carry hepatitis B virus. The key to control lies in a high standard of personal hygiene and the sterilization of equipment used in contaminated areas. Screening of patients and staff should take place regularly in high risk areas, such as renal dialysis units and laboratories. Staff members with overt hepatitis A or B should be removed from duty, but, provided proper precautions are taken, those who are chronic carriers need not be excluded from patient contact. Full barrier nursing should be used for in-patients with hepatitis A, but those with hepatitis B need only be isolated if they are in a ward containing patients unduly susceptible to infection. Hepatitis B immunoglobulin may be used on a hepatitis B negative person following an accident, but its availability should be carefully controlled.

72. VIDAL Y PLANA, R. R. and ROSSARI, G. Igiene e disinfezione: aspetti tecnici e risvolti legali. **[Hygiene and disinfection: technical and legal aspects.]** *Tecnica & Metodologia Economale*, Firenze, 1978, May/June, vol. 17, no. 3, pp. 145-148.

The need for careful disinfection and sterilization in the hospital cannot be too often emphasized, and staff should constantly be alerted to the need to observe strict rules of hygiene. So many disinfectants are available today that it is difficult to choose between them. Some germs have become resistant to disinfectants such as quaternary ammonium compounds, benzalconium chloride, and chlorhexidine. The author would like to see much more research carried out on disinfectants. He discusses the question of legal responsibility for physical injury due to incorrect sterilization or disinfection and concludes that if it can be shown that the injury would not have occurred if there had been no negligence in carrying out disinfection, or if unsuitable or inadequate methods had not been used, then the hospital can be held responsible for the injury.

HYGIENE IN THE OPERATING THEATRE

See also Abstract No. 69

73. WHYTE, W. and others. **Reduction of bacteria in the operating room through the use of non-woven clothing.** *British Journal of Surgery*, Bristol, 1978, July, vol. 65, no. 7, pp. 469-474.

Five clothing materials were tested in a dispersal chamber and in plenum-ventilated operating rooms to assess their efficiency in reducing bacterial dispersion and surface linting. The materials were: (i) cotton; (ii) non-woven '450' fabric; (iii) Ventile; (iv) Tyvek; and (v) ceramic polyester. The disposable non-woven '450' fabric, supplied by Johnson and Johnson Ltd., was shown to be as bacteriologically effective as the closely woven, uncomfortable Ventile material. When all staff wore non-woven trousers and scrubbed staff gowns as well, a 60 per cent reduction in the bacterial particles in the air was achieved in one operating room, and 43 per cent in the other. The use of non-woven, as compared with cotton clothing, reduced the already small amount of surface bacteria by 50 to 60 per cent. The remaining bacteria would not be easily dispersed from non-woven gowns as these, together with gowns made from certain artificial materials, shed few fibres.

74. FURUHASHI, M. **A study on the microbial filtration efficiency of surgical face masks—with special reference to the non-woven fabric mask.** *Bulletin of the Tokyo Medical and Dental University*, Tokyo, 1978, March, vol. 25, no. 1, pp. 7-15.

The differences in bacterial filtration efficiency between non-woven fabric and cotton cloth masks was studied. Six types of surgical face mask were examined both before and after use: two commercial brands of non-woven face mask made of a fine glass fibre sandwiched between the non-woven fabrics, three different types of cotton cloth mask and one gauze mask. The results obtained from the disposable mask made of a glass fibre that combined with non-woven fabric proved to be the highest in performance with a bacterial filtration efficiency of 98.1 to 99.4 per cent. The bacterial filtration efficiency of the cotton masks was lower and more variable—from 43.1 to 93.6 per cent.

STERILIZATION

See also Abstract Nos. 70, 72, 98

75. MORANDINI, M. and SALVADOR, P. Sterilizzazione ospedaliera. **[Hospital sterilization.]** *Tecnica Ospedaliera*, Milano, 1978, Feb., vol. 8, no. 2, pp. 54-60.

The workings of the Tra.S.car system methods for vertical transport of material between the wards and central sterilizing area on goodslifts are described and illustrated. The containers can be loaded and unloaded automatically when the automatic Tra.S.car system is used, while with the Maxi Tra.S.car system and a special large-capacity autoclave at floor level, loaded trolleys can be passed through the autoclave. The maximum number of sterilizing cycles can also be obtained with the Tra.S.car system when a horizontal conveyor belt is used to feed and unload the autoclave. Seven diagrams illustrate the workings of the various systems.

AIR HYGIENE

See also Abstract Nos. 137, 138, 140

76. NEAL, A. D., WADDEN, R. A. and ROSENBERG, S. H. **Evaluation of indoor particulate concentrations for an urban hospital.** *American Industrial Hygiene Association Journal*, Akron, 1978, July, vol. 39, no. 7, pp. 578-582.

Total suspended particulates (TSP) were measured in two intensive care units in an urban hospital over a six-month period. The major finding of the study was that the levels of particulates in the units were low. The outdoor concentrations in the units were also low. The outdoor concentrations did not appear to be a major determinant of indoor TSP levels. Because of the different nature of the two units, particularly with respect to human activities, it was considered necessary to analyse the data by site as well as season. Such analyses revealed a significant difference in overall mean TSP levels between the two sites as well as a significant difference between season averages for each site. Based on qualitative observations, carpeting, smoking, movement of people and window ventilation appeared to influence indoor TSP levels.

SAFETY MEASURES

See Abstract No. 91

ACCIDENTS IN GAS AND DRUG ADMINISTRATION

See Abstract Nos. 137, 138, 140

FIRES AND FIRE PREVENTION

77. KOLLER, R. Brandschutz—wichtig auch in Spitälern und Heimen. **[Fire protection - important in hospitals and homes.]** *Veska*, Aarau, 1978, Aug., vol. 42, no. 8, pp. 403-404.

Fire alarm and fire protection measures for hospitals described in this paper include: electronic fire alarms (which should be in every room); the automatic fire alarm centre, with which the room alarms are linked and which sets in motion general warnings and automatic extinguishers, activates fire protection doors and calls the fire service; and special automatic Halon 131 gas extinguishers for computer installations, laboratories and other areas, with expensive equipment. Sprinkler plants for workshops, stores, laundry, etc., also play a useful role.

78. TIEZZI, I. Sicurezza all'incendio negli ospedali e nei luoghi di cura. **[Fire safety in hospitals and in centres of care.]** *Tecnica & Metodologia Economale*, Firenze, 1978, May/June, vol. 17, no. 3, pp. 153-154, 156, 158-159, 161.

The author considers the essential points relating to fire precautions in the hospital. The main causes of fire are human error or electrical faults, and the use of individual heaters and faulty arrangements for waste disposal are often to blame. The main

danger to life is from smoke, and particular attention should therefore be paid to preventing the smoke from spreading; smoke filters, anti-smoke doors, and refuge zones for those who cannot escape quickly. The use of fire detection devices, fire-resistant building materials, compartmentalization in buildings, and fire barriers is briefly discussed, and the author stresses the need for the hospital to have its own properly trained and equipped fire fighting team.

79. CHANDLER, S. E. **Trends in hospital fire statistics.** *Hospital and Health Services Purchasing*, London, 1978, July, pp. 215-216.

This survey is based on a Building Research Establishment Current Paper now in preparation. From 1971 to 1974, 7,079 fires in hospitals were attended by fire brigades. Nearly all the increases in fires in these years were confined to the item or materials ignited, showing that the reporting of small fires has improved following the severe losses at Shelton (1968) and Coldharbour (1972). Fires in wards doubled in the period under question. Smokers' materials, malicious ignition and cooking applicances accounted for a large percentage of hospital fires. Night fires carried a higher risk to life and over half such fires occurred in wards and bedrooms, where there were 74 deaths and 91 injuries. In non-patient areas there were 83 casualties, but only two deaths. Multiple death fires in psychiatric hospitals remain a major problem although, in terms of available beds, fires do not occur any more frequently in psychiatric than in other hospitals.

80. REED, J. I. **Fire alarm systems.** *Hospital and Health Services Purchasing*, London, 1978, July, pp. 217-218.

There are three main elements in most automatic fire detection systems: (i) the detection circuit; (ii) the central equipment panel; and (iii) the alarm signalling equipment. The two most common detection systems are the heat sensitive and the smoke detector. The former systems may be either fixed temperature or rate of rise types and the latter are either optical smoke or ionization smoke detectors. All these devices and their operations are described. The choice of detection device depends upon the normal temperature of the area concerned and the type of fire likely to be produced. The type of circuit chosen for any system should take account of reliability, cost and availability of maintenance. Five types of circuit are described. Indicator control equipment, audible warnings and control devices form other components of an automatic system. Four call systems for summoning the fire brigade are also described.

PLANNING FOR MASS EMERGENCIES

81. JEANNET, E. Organisation extra-hospitalière en cas de catastrophe. **[Disaster planning.]** *Veska*, Aarau, 1978, Aug., vol. 42, no. 8, pp. 409-413.

A peace-time catastrophe, with mass casualties, could result in chaos at hospitals unless suitable plans have been made in advance for dealing with such situations. Such plans should include arrangements for triage at the site of the catastrophe and for the proper disposal of casualties. As an example the catastrophe planning developed in the Vaud Canton of Switzerland is described. In addition to careful planning, exercises with simulated casualties should be carried out at least once a year.

THE PATIENT

WELFARE OF THE PATIENT

See also Abstract Nos. 58, 119

82. BARIC, L. **'Communication barriers': an aspect of doctor-patient interaction.** *Journal of the Institute of Health Education*, Sheffield, 1978, vol. 16, no. 2, pp. 39-52.

The doctor/patient relationship is not always effective due to certain barriers. This paper first analyzes the barriers in relation to the expectations of doctors and patients. The definition of barriers is then linked to the conceptual models of communications. These can, in general, be grouped into two main categories; engineering and linguistic models. Three of the many barriers identified in the literature are examined: (i) the different orientation of doctors and their patients with respect to the systems and the interpretation of the outcome of an interaction between the two; (ii) the so-called 'double find' in which the patient finds himself because of the doctor's expectations about him; and (iii) the difference in the opinions about the amount of optimal communications for a successful doctor-patient interaction. Finally the paper examines the role that health education can and should play in increasing the effectiveness of doctor-patient communications.

83. Oplevelser som patient i en intensiv afdeling: isoleret, stum, afhängig og ensom. **[Experiences as a patient, in an intensive care unit; isolated, unable to speak, dependent and lonely.]** *Sygeplejersken*, København, 1978, Aug. 9, no. 31, pp. 16-20.

A 62-year-old author developed pneumonia in January 1972 and was admitted for a long period of time to an intensive care ward. He was unconscious or psychotic on several occasions, and semiconscious at others. In a description of his subjective experience written five years later, he emphasizes his feelings of abandonment and isolation from staff, from other patients, and from the entire world except his wife, who continued to visit him throughout his time in hospital. He describes being totally unjustifiably suspicious of certain members of staff, and overwhelmingly grateful for small evidences of human feeling, such as when one young nurse talked about her children, or another nurse remembered having read a book by him when she was at school. At a chance meeting with the professor in charge of the department some time after discharge, the professor congratulated him on his survival and recovery, on his will to live and will to co-operate. He asks why, if he was regarded as being so co-operative, he was never told anything about his condition or the course of treatment currently being adopted. Was it because the staff concluded that he, personally, at any given moment was not in a fit state to be told anything—or, a far more serious perspective—is it normal practice not to tell anybody anything, and in all cases to assume that the staff knows best, and that the patient's job is passively to accept anything and everything done to him?

84. KHASSIS, U. and TILLMAN, I. **Integration of the health education component in the opening of a new regional hospital in Jerusalem.** *International Journal of Health Education*, Geneva, 1978, vol. 21, no. 2, pp. 116-119.

The Hebrew University Hadassah Hospital, Mount Siopus, Jerusalem, is now

functioning as a university regional hospital providing comprehensive services to an area of the city in which several different communities reside. To educate both staff and patients in the concept of the community hospital, a broad health education programme, including communication and public relations, was developed. Potential patients were informed in community clinics of the hospital's opening, its regulations and the facilities it offered as they became available. A course for kitchen and cleaning workers—a priority in staff education, was presented in both Hebrew and Arabic. The Infection Committee developed an illustrated isolation card to overcome the language difficulties when outlining standards for isolation practice.

TRANSPORT OF PATIENTS

85. HAMPTON, J. **Paradox at the heart of a high speed service.** *Health and Social Service Journal*, London, 1978, July 21, vol. 88, no. 4600, pp. 819-820.

A five-year study was carried out in Nottingham to determine how many lives were saved by the use of an ambulance equipped to deal with suspected myocardial infarction and manned by specially trained staff. For the earlier phases of the study period the cardiac vehicle was used only part of the time and there appeared to be no advantage in using it, largely because it was not always sent quickly enough, or to the right cases. During the final stages of the study the cardiac ambulance was restricted to a random selection of 999 calls, but it still proved impossible to get the one ambulance to the right cases and no lives were saved. Six cardiac ambulances would be needed to make the service effective in a conurbation the size of Nottingham. These, together with the training of the crews, would be very expensive and their value would have to be considered in relation to other projects.

HOSPITAL CARE

See also Abstract Nos. 23, 31, 103, 111, 112, 117, 148-150

86. MCDOUGALL, G. M. and TAYLOR, D. E. **The interdisciplinary team in the general hospital.** *Canada's Mental Health*, Ottawa, 1978, June, vol. 26, no. 2, pp. 12-15.

This paper first defines the interdisciplinary team approach and discusses its rationale, membership and internal and external relationships. The disadvantages of the traditional vertical hierarchical organization of hospitals are outlined. A Puretional 'inverted pyramid' organizational structure is preferred. This structure, with the goal of staff-patient interaction uppermost, allows for horizontal communication, free giving and receiving of information, giving of opinions and evaluations, and delegated decision making. The many problems in the development of interdisciplinary teams are due to three basic difficulties: (i) previous professional education and resultant attitudes of the various disciplines; (ii) lack of co-operative working skills and ineffective use of group dynamics theory; and (iii) non-acceptance of a progressive organizational structure.

87. SCHULTZ, R. **The psychology of death, dying and bereavement.** Reading, Mass. & London, Addison-Wesley, 1978, [xi], 197pp. £4.50

This book provides a comprehensive review and critical analysis of the most recent

literature and research information available on death, dying and bereavement. The topics covered include: attitudes about death; the demography of dying; psychological aspects of living and dying; the physiological aspects of living and dying; the physiological and behavioural consequences of bereavement; death education; and the social-psychological determinants of longevity. A bibliography is included (pp. 172-187).

88. REZLER, A. G. and STEVENS, B. J. **The nurse evaluator in education and service.** New York & London, McGraw-Hill, 1978, xii, 333pp. £12.70

This book collects together the basic ideas about nursing evaluation, and is intended to help nursing staff become more knowledgeable about the planning and implementation of evaluation in various nursing settings. It is divided into four sections. Part one presents the general concepts applicable to both nursing education and nursing service; part two includes chapters on the evaluation of students, teachers and educational programmes; part three includes chapters on the evaluation of patient care, staff, staff development schemes, and the organization and structure of nursing services; and part four considers methods of reporting and analyzing evaluation data. References are included after each of the 16 chapters.

89. COLEMAN, J. R. and KAMINSKY, F. C. **Ambulatory care systems Volume V. Financial design and administration of Health Maintenance Organizations.** Lexington, Mass., Lexington Books, 1977, xxx, 369pp. £16.50

This books considers the design activities and decisions that must be made in connection with preparing a facility plan and management plan for a Health Maintenance Organization (HMO). The book is arranged in two parts. The first part considers the design of the administrative component of the HMO, estimating the annual space needs, setting premiums and service prices for the initial year of operation and estimating plan costs and revenue. The second part describes the financial planning model. The eight chapters cover: introduction; planning the administrative components; estimating the space requirements; designing a space structure for services; determining revenue costs and financial need; financial planning; the basic structure of the financial planning model; and use of the financial planning model. Five appendices are included which cover: name, location and initial year of operation of several prepaid care plans; glossary; financial structures of several group practice HMO prototypes; description of the HMO census utilization data file; and a description of FPM system files.

DISCHARGE OF PATIENTS

See Abstract Nos. 131, 132, 155

HOME CARE, AFTER-CARE

See Abstract Nos. 93, 129, 150

SPECIAL DEPARTMENTS

OPERATING SUITES

See Abstract No. 90

ANAESTHESIA

90. ZINGARETTI, G. and others. Sul dimensionamento dell' organico medico nel servizio anestesia e rianimazione proposta metodologica. **[A method for calculating the number of staff required for an anaesthetic and resuscitation unit.]** *Ospedale*, Torino, 1978, July, vol. 31, no. 7, pp. 171-174.

The medical staff in the anaesthesia and resuscitation department are required to assist with surgery, perform resuscitation, give intensive care post-operatively, assist with obstetric emergencies and with instrumental diagnosis, and provide 24-hour cover for emergency surgery. The author proposes a method of calculating the number of anaesthetists required for the department. He illustrates his method with examples from a regional hospital and a provincial general hospital, and shows that the norms established in 1969 in Italy are too low.

91. SPENCE, A. A. and KNILL-JONES, R. P. **Is there a health hazard in anaesthetic practice?** *British Journal of Anaesthesia*, London, 1978, July, vol. 50, no. 7, pp. 713-719.

Although there is no proof that the environment of the operating theatre is a direct health hazard, measures should be taken to reduce contamination as much as possible. Toxicity of theatre pollution can be measured by: (i) experiments with animals; (ii) limited experiments using human volunteers; (iii) epidemiological surveys, which are too small to be very helpful; and (iv) mortality surveys. The author reviews the literature on studies carried out using these methods under the headings: (i) reproduction and the foetus; and (ii) other diseases, including cancer and liver disease. Although no studies are conclusive, it is reasonable to suppose that the risk of spontaneous abortion is increased among female anaesthetists. The effect on foetal development and infertility warrants further study. Anaesthetists do not appear to be at high risk from any particular disease, except viral hepatitis. However, surveys are currently being carried out in the United Kingdom and the United States.

PHARMACY

92. JACKSON, J. C., ANDERSON, R. K. and MCGUIRE, R. **Decentralized pharmacist concept solves unit dose problems.** *Hospitals*, Chicago, 1978, April 16, vol. 52, no. 8, pp. 107, 108, 110.

LDS Hospital, Salt Lake City, installed a unit dose system during 1974-75, but a number of major problems arose. At a brainstorming session to seek solutions to these problems, the decentralized pharmacist concept evolved. The concept was tested in the hospital and found to be effective in meeting pharmacy's needs. The concept

entails a pharmacist and a portable master medication trolley situated on the nursing units. The pharmacist uses the trolley, which is a miniature pharmacy on wheels, to supply nursing units with all of their medication needs. The operation of the system is described, with particular reference to stocking. The cost of the new system has been negligible. At present, five pharmacists handle the in-patient pharmacy and dispensing services each day. Each pharmacist is responsible for about 100 beds.

93. SOLOMAN, D. K. and others. **Pharmaceutical services to improve drug therapy for home health care patients.** *American Journal of Hospital Pharmacy*, Washington, 1978, May, vol. 35, no. 5, pp. 553-557.

A 12-month study was conducted in a home care agency based at a rural community hospital to identify specific problems associated with drug therapy of home care patients and to evaluate the contribution made by the pharmacist. The majority of the agency's patients were elderly and had multiple chronic disorders. The services provided by the pharmacist were: (i) maintenance and surveillance of comprehensive patient medication profiles; (ii) attendance at daily multidisciplinary conferences; (iii) recommendations on drug therapy; and (iv) drug information. Information collected by the pharmacist in home interviews of 46 patients was evaluated. Analysis of subjective data revealed that, more than any other prescription drug categories, analgesics were overused, while bronchodilators and antibiotics were underused. Prior to the visit of the pharmacist, less than half of the patients reported receiving oral information concerning their medications. Evaluations by attending physicians and nurses confirmed the need for continued pharmacist involvement in the home care service. As a result of the study, a role model is outlined for pharmacists serving home care agencies.

94. HLYNKA, J. N. GOLIGHTLY, L. K. and WILLIS, G. A. **The B.C. Drug and Poison Information Centre.** *Canadian Journal of Hospital Pharmacy*, Saskatoon, 1978, July/Aug., vol. 31, no. 4, pp. 129-131.

The British Columbia Drug and Poison Information Centre was formally established in 1974 to serve 100 provincial hospitals. Its administrative organization consists of: a management committee (with representatives of the Ministry of Health and University of British Columbia); a professional advisory committee (with representatives from medical, nursing and pharmacy professional associations); and a medical review board (10 physicians from various specialties). The centre is located in St. Paul's Hospital, Vancouver, adjacent to the hospital library. Two basic drug information services are provided: *Drug Information Reference*, giving monograph information on over 300 drugs most frequently used in British Columbia; and dealing with specific requests. There are also two types of service on poisons: B.C. Poison Information Cards; and those dealing with requests for information on unknown toxins and difficult management cases. The staff of the centre spend about one third of their time on educational programmes, including lectures, courses and drug and poison information newsletters.

95. GREENLAW, C. W. and ZELLERS, D. D. **Computerized drug-drug interaction screening system.** *American Journal of Hospital Pharmacy*, Washington, 1978, May, vol. 35, no. 5, pp. 567-570.

At Holy Cross Hospital, Fort Lauderdale, Fla., the pharmacy automated drug

interaction screening (PADIS) system has been added to the existing pharmacy computer system. The system has been designed to function as a batch program which is run once daily to screen all patient medication profiles for drug interactions during the same period and to print a daily patient drug interaction profile. The data base contains approximately 24,000 drug interaction combinations of drugs marketed in the United States and also foreign and investigational drugs that have been implicated in drug interactions. The computer detects potential drug interactions in approximately nine per cent of the patients per day at the 635-bed hospital.

96. CHRISTENSEN, D. B. **Drug-taking compliance: a review and synthesis.** *Health Services Research*, Chicago, 1978, vol. 13, no. 2, pp. 171-187.

The literature to 1976 on patient compliance in taking prescribed drugs is reviewed with some criticism of the methodologies used in the studies. Patient, provider, disease and drug factors associated with compliance are analyzed. Until recently the lack of a well-developed theory on model of compliance behaviour was a major problem. The health belief model appears to be the most applicable model. It is based the patient's own perceptions of health rather than on objective measures or the judgment of health professionals. In brief, the model postulates that health behaviour is determined by one's 'readiness to act'. A modification of this model is proposed that views drug-taking compliance as a response by the patient to a sequence of testing and illness-redefinition stages during the course of an illness. A list of 66 references to the literature is included.

97. WYATT, B. K. **Today's planning and implementation of unit dose in a 200-bed hospital.** *Hospital Pharmacy*, Philadelphia, 1978, June, vol. 13, no. 6, pp. 311-312, 318-319, 328-329.

At the Lawrence Memorial Hospital, Kansas, a unit dose drug distribution system was carefully planned and implemented by the pharmacy department without encountering many problems. The pharmacy provides the nurse with one dose of any one drug. Cassettes of such doses may be exchanged once or twice daily, according to when prescriptions are written out in any one hospital. If large enough drawers are provided for the cassettes, a once daily exchange is sufficient which reduces the man-hours needed to work the system. The profile forms were designed to correspond to the design of the drawers. Drug doses are sent in envelopes through a pneumatic tube system, and the distribution schedule on the envelope corresponds with the shift compartment of the drawer. A unit dose discrepancy form and a form used for each day's packaging are also described. The pharmacy stocks over 600 drugs in a circular packing station.

98. KAY, J. B. **Environmental control in preparation of medicines 3.** *Manufacturing Chemist and Aerosol News*, London, 1978, Aug., vol. 49, no. 8, pp. 56, 59, 60, 63.

In addition to the requirements for a clean room, aseptic conditions require the use of HEPA filters for the filtration of air entering the area, and the exclusion of all micro-organisms including spores for the area. The simplest form an aseptic area can take is that used for aseptic dispensing; the most complicated is that used in industry for the aseptic manufacture and filling of products such as vaccines and creams. This paper considers the requirements of each of these extremes under the headings: entry procedures and techniques for people; entry procedures for materials, components and

products; and cleaning and disinfection. Tests to be undertaken in the commissioning stage are: filler efficiency; air velocities; pressure differential; air flow patterns; particular air counts; and microbiological effects. When commissioning tests are completed satisfactorily, detailed records summarizing the data must be made for use in monitoring and maintenance.

LABORATORIES

99. BARNETT, R. N., MCIVER, D. D. and GORTON, W. L. **The medical usefulness of stat tests.** *American Journal of Clinical Pathology*, Philadelphia, 1978, May, vol. 69, no. 5, pp. 520-524.

Although stat tests are one of the most important features of clinical laboratory performance, there is little significant discussion of the subject in the literature. A questionnaire was sent to 53 hospitals (20 small, 20 medium and 13 large) to obtain information on their current practices with regard to tests performed on a stat basis. This covered: turn round time; whether restrictions are placed on the use of stat tests; who places such restrictions; whether the stat tests are judged to be less accurate or less precise than the routine methods; whether there is a stat laboratory; how stat tests are reported; whether a priority system for determining stats exists; and whether special stat instruments are present in the laboratory. The results are presented in six tables and discussed. Viewed from the perspective of laboratory efficiency and cost controls, stats are disastrous; to cope with them properly requires a staff much larger than is needed to handle routine requests. What can be avoided by better routine scheduling should be avoided; what needs to be done stat should be done rapidly and efficiently.

100. ALLEN, P. W. and ANGUS, B. V. **Computer-output microfilm in an anatomic pathology laboratory.** *American Journal of Clinical Pathology*, Philadelphia, 1978, May, vol. 69, no. 5, pp. 537-543.

In the division of histopathology, Institute of Medical and Veterinary Science, Adelaide, the names of patients, with age, sex, laboratory accession number, systematized nomenclature of pathology (SNOP) diagnostic code numbers, and concise diagnoses written in English, are printed on computer-output microfiche. Four separate and updated microfiche files of cases accessioned over the preceding five years are prepared every six months: alphabetical order of patients' names; laboratory accession number order; SNOP morphology code number order; and SNOP topography code number order. These files allow rapid retrieval of a summarized diagnosis, and also act as directories to the complete pathology reports. Carbon copies of complete typewritten reports are manually microfilmed in laboratory accession number order on automatically-marked 16 mm. roll microfilm which is stored in cassettes. Microfilmed reports can be retrieved rapidly, projected on a screen and, when needed, printed by a roll microfilm reader-printer. The system has resulted in a great saving of valuable laboratory space and in markedly increased laboratory efficiency.

101. KRIEG, A. F. and others. **An approach to cost analysis of clinical laboratory services.** *American Journal of Clinical Pathology*, Philadelphia, 1978, May, vol. 69, no. 5, pp. 525-536.

This paper describes the development of a system that provides information about costs related to specific laboratory costs. These costs are derived from: (i) labour and

material actually used for specific tests; (ii) allocation of costs for labour and material shared by several different tests; and (iii) allocation of supervisory and management costs. The 'cost' of a specific procedure is a theoretical constraint that is significantly affected by the method chosen for allocation. There is no cost-analysis system generally accepted by all clinical laboratories. Since third-party payers may base future reimbursement on costs rather than charges, accurate systems for clinical laboratory cost analysis may have some practical value.

DIAGNOSTIC X-RAY DEPARTMENT

See also Abstract No. 13

102. WINTER, J. **Efficiency of utilization of a computed tomography scanner.** *American Journal of Roentgenology*, Springfield, 1978, July, vol. 131, no. 1, pp. 89-93.

Efficient use of diagnostically effective, but expensive computed tomography brain scanners requires understanding of time factors influencing patient throughput. In a study carried out at the University of California Los Angeles Medical Center on the use of an EMI mark I brain scanner, the average number of patients studied was 16.3 per 15.5 hour workday for an average of 52.7 minutes per patient. Of the patients, 51.5 per cent were in-patients, 45 per cent received intravenous iodinated contrast infusion, and 33 per cent had studies showing significant abnormalities. The X-ray tube was on 51.1 per cent of the time the scanner facility was opened, with scanning averaging 34.6 minutes per patient. The average number of images obtained was 10.4 per patient at 3.4 minutes per image. Patient handling, including contrast infusion, accounted for an additional 16.2 minutes per patient or 34.4 per cent of the total time. Anaesthesia lengthened the procedure by one hour, but was needed in only 4.5 per cent of cases. Flexible scheduling was essential since 14 per cent of the patients failed to keep their appointments or had their studies cancelled. The results suggest that the faster, more expensive scanners now being introduced, while having diagnostic advantages for body scanning, will not significantly decrease cost per patient when used for brain scanning compared with the first generation machine studied.

103. BAHR, A. L. and HODGES, F. J. **Efficacy of computed tomography of the head in changing patient care and health costs: a retrospective study.** *American Journal of Roentgenology*, Springfield, 1978, July, vol. 131, no. 1, pp. 45-49.

Detailed analysis was undertaken of all neurological and neurosurgical patients admitted to Johns Hopkins Hospital for six months prior to and six months after the installation of a computed tomography head scanner. Data showed that computed tomography resulted in decreased cost of more than $2,000 per patient and shorter length of stay by seven days in patients with extracerebral collections, and more than $2,500 and eight days reduction in those with tumours. A group matched by computer for age, diagnosis and physician showed decreased costs of more than three days per admission. Increased costs were shown in patients with cerebrovascular disease after computed tomography. Change in method of workup with fewer invasive studies for all patients and significant increases in cost of diagnostic workup were demonstrated. There was no difference between the two groups in morbidity and mortality. The results suggest that computed tomography of the head may reduce cost and length of stay in certain patient groups and frequently alters patient workup.

104. O'KANE, P. C. and GOUGH, A. D. **An evaluation of patient demand in a hospital radiology department.** *Hospital and Health Services Review*, London, 1978, July, vol. 74, no. 7, pp. 226-229.

The radiology department studied provides services for both in-patients and out-patients of a 536-bed general and district hospital on the outskirts of Belfast. The average number of arrivals per week was 568, with 92 per cent arriving from Monday to Friday, the average attendance being 28 per cent higher on Monday. A large percentage of patients arrived between 8.00 and 17.00 hours. Each patient source generated its own demand pattern; four clinics being responsible for 76 per cent of all attending out-patients. A similar pattern was observed for all in-patient referrals and six categories of examination accounted for 81 per cent of all the work involved. This simple analysis does not present a solution to the organizational problems of an X-ray department, but helps to identify areas where more detailed study, applied to a computer model, could result in an improved use of resources.

REHABILITATION

105. SHEPPARD, J. L., ROTHWELL, R. W. J. and SMITH, R. C. **The vocational element in rehabilitation; rehabilitation counselling.** *Medical Journal of Australia*, Glebe, 1978, May 20, vol. i, pp. 558-560.

The broad scope of rehabilitation programmes requires the combined knowledge and skills of a number of different professions. Among these is the relatively new profession of rehabilitation counselling. In Australia, the development of this discipline has been closely linked with services emphasizing vocational rehabilitation, and most counsellors are now employed by organizations conducting such services. The variety of skills and broad range of knowledge required for effective counselling are outlined and some of the day-to-day activities of rehabilitation counsellors are mentioned. The only comprehensive training course for rehabilitation counsellors is that provided since 1975 by Cumberland College of Health Sciences, Sydney. The course lasts two years full-time, or one year full-time plus two years part-time while working in the field or a related discipline. From 1978, the college is also providing a one-year diploma course for graduates.

106. BINI, V. A proposito di centri di riabilitazione. **[With reference to rehabilitation centres.]** *Tecnica Ospedaliera*, Milano, 1978, Feb., vol. 8, no. 2, pp. 19-27.

Current health policy in Italy stresses the importance of early prevention and post-acute rehabilitation. Using a study by F. C. Salmon (1973) 'Time-Saver Standards for Building Types' as a basis, the author presents various practical solutions for the construction and organization of a rehabilitation centre. The principal zones are the consultation rooms, physiotherapy, occupational therapy, research area, prostheses and aids, workshops, social instruction area (for the deaf, stammerers, etc.), and offices. Minimum dimensions for each zone are proposed. The designer must bear in mind the fact that many patients will be in wheelchairs. The author suggests that physiotherapy and occupational therapy should together occupy half of the available space. He suggests a ground plan for the whole centre, and includes sketches of the consultation rooms and physiotherapy area.

PHYSIOTHERAPY DEPARTMENT

107. PRATT, J. W. **A psychological view of the physiotherapist's role.** *Physiotherapy*, London, 1978, Aug. 10, vol. 64, no. 8, pp. 241-242.

The physiotherapist is particularly well suited to play a wide therapeutic role. She spends a relatively large amount of time with the patient, providing the opportunity to discuss the condition to be treated, the therapy to be undertaken and a number of related topics. The physical contact with the patient may create a special kind of communication and the treatment given is often immediately beneficial, giving ample opportunity for the physiotherapist to help with psychological as well as physical needs. The patient's co-operation and willingness to learn will depend upon his attitude to the therapist, who should have positive regard for the patient and empathic understanding. Therapy should always focus on the person to be helped.

OCCUPATIONAL THERAPY DEPARTMENT

108. ALEXANDER, P. **Making a difference: the focus for occupational therapy.** *Medical Journal of Australia*, Glebe, 1978, June 17, vol. i, pp. 641-642.

The number of students in occupational therapy schools in Australia has increased significantly over the last five years. Degree courses are offered, integrating clinical experience with academic courses. Competence in practice is dependent upon the therapists' ability to establish relationships, solve problems and be adaptable and tolerant. Examples are given of the differing types of patient the occupational therapist may be required to help. Cities are better served by occupational therapists than more rural areas. Therapists are employed most often in hospitals, in community and rehabilitation centres and with voluntary organizations, but they also enjoy working with other members of a health team.

DEPARTMENTS FOR SPECIAL THERAPY

See Abstract Nos. 129, 130

INTENSIVE CARE UNITS

See Abstract No. 83

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See Abstract No. 139

CASUALTY AND ACCIDENT

See also Abstract No. 133

109. VERTESI, L. **The paramedic ambulance: a Canadian experience.** *Canadian Medical Association Journal*, Ottawa, 1978, July 8, vol. 119, no. 1, pp. 25-29.

The paramedic ambulance service at the 420-bed Royal Columbian Hospital, New

Westminster, B.C., began in 1972 as a volunteer effort; in 1975 protective legislation and government finance allowed expansion to its present format. A select group of experienced ambulance attendants have received more than 1,000 hours of clinical teaching spread over a whole year and are graded as emergency medical assistants, level III (EMA IIIs). During a 27-month period, 6,968 patients were attended by an EMA III crew; of these 857 (12.2 per cent) required special procedures. Details of these 857 patients are given in six tables. Although the most important benefit of the improved care was the prevention of sudden death in a large proportion of persons with crises due to coronary artery disease, the skills learned to provide basic life support are applicable to a wide variety of other disorders that can result in death before the patient reaches hospital.

110. CUE, F. and INGLIS, R. **Improving the operations of the emergency department.** *Hospitals*, Chicago, 1978, July 1, vol. 52, no. 13, pp. 110-113, 119.

The high demand for emergency department services has created concern about emergency department operations and how they can be improved. To answer some of the key questions involved, the operations of 20 emergency departments in the Washington, D.C., area were analyzed. The review covered patient use, treatment times, X-ray examinations, laboratory tests, staffing levels, and facility planning. The results suggest that economies of scale or increased productivity in larger hospitals may occur in those departments having minimum patient contact and processing uniform units in a central location.

111. ANWAR, R. A. H. **Skills and procedures in emergency medicine: room for controversy.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, May, vol. 7, no. 5, pp. 198-201.

A study of patterns of consensus and of conflicting opinion amongst directors of emergency medicine, surgery and internal medicine was carried out to discover under what conditions doctors trained in emergency medical care should perform the 30 skills listed in the Emergency Medicine Conditions/Skills List produced by the American College of Emergency Physicians. The response revealed wide variations in opinion about the required skills and the circumstances under which the procedures should be carried out. Slightly more than one third of the procedures on the list were agreed upon by 80 per cent of the directors as procedures carried out by trained emergency physicians.

112. KASZUBA, A. L. and GIBSON, G. **Severity, satisfaction and symptom resolution in patients of emergency medicine residents.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, May, vol. 7, no. 5, pp. 192-197.

This study compares emergency department patients treated by emergency medicine residents with those of other clinicians working in the emergency department, specifically with regard to presenting conditions and subsequent patient satisfaction and health. The study was carried out in the Adult Emergency Department of the Johns Hopkins Hospital, East Baltimore, Maryland. The results revealed that emergency medicine residents met fewer severe medical cases than medical house-staff. There was no significant difference among the clinician group. Pain and anxiety levels improved for all patients. The study has demonstrated the need to re-examine the training offered

to emergency department staff in order to be able to define the status of emergency medicine.

OCCUPATIONAL HEALTH

See Abstract Nos. 91, 140

DAY HOSPITALS

See also Abstract No. 151

113. WILLIAMSON, F. **A day hospital within the divisions of a troubled community: a report from a psychiatric day hospital in Belfast.** *International Journal of Social Psychiatry*, London, 1978, vol. 24, no. 2, pp. 95-103.

Alexandra Gardens Day Hospital, which opened on 23 August 1971, replaced Clifton Street Day Hospital, the first ever to be established in Belfast. It is a large early 20th century dwelling house, modernized and converted to function as an acute psychiatric treatment centre, and as an alternative to treatment in an in-patient psychiatric unit. On the ground floor are the reception area, out-patient department, consultants' interviewing rooms and secretarial offices. The day patients spend from 0930 to 1630 Monday to Friday on the first floor where there is a comfortable lounge, occupational therapy room, recreation room, kitchen, hairdressing salon/launderette, staff common room and offices. On the second floor, which is used for treatments, there is a 10-bed ward divided into three sections and two quiet rooms. Patients and staff take their meals together in the 40-seat dining room which is in an annexe. The 369 patients admitted during the first 21 months are reviewed and compared with 140 patients admitted to the Clifton Street Day Hospital over an eight-month period.

INFECTIOUS DISEASES AND ISOLATION

See Abstract Nos. 62, 71

CHILDREN

See also Abstract No. 152

114. VAN EYS, J., editor. **Research on children: medical imperatives, ethical quandries and legal constraints.** Baltimore, Md. & London, University Park Press, 1978, xiii, 152pp. £5.95

This book examines the balances that need to be maintained between discovering new and better ways of treating childhood disorders and protecting the welfare and rights of paediatric patients. Aspects considered include: the rights of the child; the medical imperative; ethical quandries; legal and societal constraints; integration of the problem and the problems of ethical research and the problems of being a child. Beginning with the recognition that children have biological differences requiring separate investigation, the authors contrast the needs of scientific progress with the ethical and legal aspects of the child as guinea pig.

115. TILLER, J. W. G. **Psychiatric consultations in a children's hospital.** *Medical Journal of Australia*, Glebe, 1978, May 20, vol. i, pp. 532-535.

The records of all referrals (191 patients) to the department of psychiatry from the medical and surgical wards of the Royal Children's Hospital, Melbourne, were studied. The referral rate approximated to two per cent of the admission rate, and patients who were referred stayed in hospital longer than three times the average stay for all in-patients. The hospital's medical units supplied 69 per cent of referrals and the rest came from the surgical units. Main diagnostic categories for patients under one year of age were congenital and metabolic disorders (35 per cent), and psychosocial problems which included maltreatment and children at risk (58 per cent). The records for patients between one and 14 years of age imply that over 50 per cent of them had family social problems or behavioural disorders. Of patients over 14 years of age, 93 per cent had affective disorders. The study clearly indicates the urgent need for prospective studies of children referred to psychiatrists, the incidence and prevalence of psychiatric morbidity in children's hospitals, the numbers of children needing specialist psychiatric assessment or treatment, and other services that may be necessary. Further, the need for constant close liaison between paediatrician and psychiatrist is emphasized.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 15, 20, 133

116. MOORE, D. **Geriatrics—country style.** *Nursing Times*, London, 1978, July 6, vol. 74, no. 1109, pp. 1139-1141.

Newholme Hospital, Bakewell, Derbyshire, provides care for 69 geriatric patients and 60 residents from Bakewell and the surrounding area. The decor is cheerful, recreational activities and outings are encouraged and open visiting is allowed. The physiotherapy staff are a valuable part of the caring team and visits from hairdressers are a great help to morale. Medical care is provided by two local general practitioners and the consultant geriatrician based at Walton Hospital, Chesterfield. Some patients are admitted for short periods to allow those looking after them to have a break. Patients' ability to look after themselves is carefully assessed before discharge and the community services and voluntary organizations are alerted. A Home Care Aide Service is also available in the area.

117. IRVINE, R. E., BAGNALL, M. K. and SMITH, B. J. **The older patient: a textbook of geriatrics.** 3rd edition. London, Hodder & Stoughton, 1978, x, 230pp. £2.95

The third edition of this book considers the changes that have taken place in the health services during the past few years, which exist to help the older patient. The book is in two sections which consider the older patient and his care; and the older patient and his illness. The nursing of the older patient is discussed against a description of the process of ageing and the social problems of old age. Attention is given to the needs of the relatives who share responsibility with the hospital and social services when an old person is ill or infirm. Information is included about medical, surgical and psychiatric problems.

118. McCLELLAND, M. **Japan's modern approach to an age-old problem.** *Nursing Mirror*, Sutton, 1978, Aug. 17, vol. 147, no. 7, pp. 13-15.

The Tokyo Metropolitan Geriatric Hospital is a modern building with 700 beds and is adjacent to the Youikei Nursing Home, a geriatric rehabilitation centre with 500 beds. The hospital is organized like an acute hospital, the patients, who are all over 65, being admitted under the consultant appropriate to their main condition. At Youikei a typical ward has 40 beds in six-bedded and four-bedded bays and some single rooms. The problems of geriatric nursing are similar to those in the United Kingdom and the standard of care and equipment provided is very high. Facilities for rehabilitation are extensive and relatives play a large part in therapy. Events are organized to help the patients maintain their interest in the outside world. There is little home nursing in Japan but public health nurses play a similar role to health visitors in the United Kingdom. Associated with the hospital is the Institute of Gerontology which promotes research into all aspects of ageing.

119. STEVENSON, M. J. **A CHC patient attitude survey.** *Hospital and Health Services Review*, London, 1978, July, vol. 74, no. 7, pp. 224-225.

Stockport Community Health Council carried out a patient attitude survey among residents of the area's long-stay hospital. Out of a total of 80 residents, 47 participated and 41 were satisfied with the hospital's general care of its patients. However, there were some critical comments which fell into the following four main areas: (i) staff; (ii) food; (iii) routine and equipment; and (iv) recreational and other activities. Frustrations resulting from lack of personal choice were displayed. The survey was supported by the officers of the local National Health Service administration, who were informed of its findings. Meetings with staff and residents gave the caring staff an opportunity to reply and certain problems concerning recruitment and catering were explained. The Survey showed that co-operation between the Community Health Council, the health service officers and the Area Health Authority could help the physically dependent to take a more positive part in running their lives.

120. SMITH, H. L., SHORTELL, S. M. and SAXBERG, B. O. **New directions for employee benefits.** *Journal of Long-Term Care Administration*, Washington, D.C., 1978, vol. 6, no. 2, pp. 20-29.

This paper reports on an initial investigation into staff benefit policies in 30 long-stay care facilities. The results indicate that merit salary increases, paid holidays, and health insurance plans are the most commonly offered financial benefits. Flexible hours, rest pauses and coffee breaks, leaves of absence, staff counselling, catering and continuing education are the most used non-financial benefits. Very little differentiation is made between benefits offered to supervisory and non-supervisory staff. As the size of the organization and the staff increases, more staff benefits are offered. The general conclusion is that salaries and wages are constrained by sources of revenue as well as internal and external pressures; administrators must meet this challenge by seeking new directions for staff benefits.

121. FELDMAN, J., BURKE, R. E. and SCHWARZMANN, J. **Analysis of the training of unlicensed long-term care personnel.** *Journal of Long-Term Care Administration*, Washington, D.C., 1978, vol. 6, no. 2, pp. 1-11.

A study is reported of programmes for the training of nursing aides/orderlies in 10

states of the United States. The review of the collected materials demonstrated that the tangle of red tape, political and professional vested interests, legal inconsistencies, lack of co-ordination, and waste of resource effort and dollars (both public and private) is overwhelming. Essentially none of the 10 studied states has been organized to plan, co-ordinate and evaluate on an on-going basis, training programmes for unlicensed long-stay care staff. Although the content of many of the programmes was excellent, they were short-lived and ultimately ineffective. As a result of the study, guidelines are offered for training programmes for these staff. Also recommended are: the formation in each state of a community advisory committee for long-stay care manpower; and the appointment of a statewide training director/co-ordinator.

122. McKibbin, R. C. **The medical director in long-term care: policies and recent experiences.** *Journal of Long-Term Care Administration*, Washington, D.C., 1978, vol. 6, no. 2, pp. 49-60.

Evolution of the concept of a medical director for long-stay care facilities began in the mid-1960s. It seems appropriate and timely to assess medical directorships in such facilities. The role and duties of the medical director are outlined and the relationships of medical direction to the team approach and to the quality of care are discussed. Eight nursing homes and a 300-bed geriatric care centre in Connecticut were surveyed in 1976 to assess their experience with medical directors; the experience of these facilities is summarized. Although experience with medical directors is varied, it generally exhibits both desirable and at least partially-offsetting undesirable traits. A key problem is lack of active interest and involvement. This may be particularly difficult to overcome in small homes where medical direction must be a part-time activity. It is difficult to generalize because long-stay facilities themselves are so varied. Each facility will have different experiences with the medical director requirement.

123. Wolf, R. S. **A social systems model of nursing home use.** *Health Services Research*, Chicago, 1978, vol. 13, no. 2, pp. 111-128.

Causal modelling (path analysis) was applied to data from the 39 mental health catchment areas in Massachusetts to analyze the effects of socio-cultural and health resource variables on the use of long-stay care facilities. The variables were psychiatric hospital use, general hospital use, community care resources, primary care resources, long-stay care, socio-economic status, marital status/living arrangement, age, ethnicity, race, and urbanization. The variables explained 53 per cent of the variance of long-stay care use by persons of 60 years or more; 41 per cent was explained by the socio-cultural variables and 12 per cent by the health resource variables. When the data were adjusted for age, the major determinant of use of long-stay care was ethnicity; less long-stay care was used in areas with more persons who were foreign-born or had a foreign-born parent. The effects of other health resources (supply of primary care physicians and use of psychiatric and short-stay general hospitals) were small and insignificant.

CANCER

124. World Health Organization. Regional Office for Europe. **Comprehensive cancer control: report on a conference, Copenhagen, 11-15 July 1977.** (ICP/CAN 004) Copenhagen, WHO Regional Office for Europe, 1978, iv, 52pp.

This report was prepared by the Regional Office for Europe of the World Health

Organization as a result of the Conference on Comprehensive Cancer Control held in Copenhagen from 11 to 15 July 1977. The aim of the Conference was to make a critical review of all cancer control services in Europe and so to be able to advise governments and WHO on their future activities. Features considered in the Conference included: cancer in Europe in the seventies—the nature of the challenge; comprehensive cancer control—the present position in the Region; the major issues in contemporary cancer control; and recommendations. The appendices consider: the international aspects of cancer statistics; the activities of the Regional Office for Europe in the field of cancer; and list the participants at the Conference.

125. ILBERY, P. **The comprehensive cancer centre.** *Medical Journal of Australia*, Glebe, 1978, May 20, vol. i, pp. 573-576.

Comprehensive cancer centres have arisen around the world, very often on the foundations of radiotherapy departments. The Cancer Institute, Melbourne, which operates the Peter MacCallum Hospital and Clinics, is the only comprehensive cancer centre in Australia. The hospital has 120 beds at present, but the first phase of its expansion to 300 beds has recently been completed. The revolutionary open-plan design of the new hospital dispels the 'hospitalized atmosphere' and provides an environment which is not only most efficient but also psychologically sympathetic. Clinical services are organized into 15 special cancer consultative clinics, each dealing with the diagnosis and management of cancer within a particular area of the body. The institute has a staff approaching 1,200 and six linear accelerators.

126. GRABOW, R. **The clinical nurse specialist—2: the staging unit.** *Nursing Times*, London, 1978, July 13, vol. 74, no. 28, pp. 1168-1169.

The 'staging' process for patients with cancer involves many routine investigations before and during treatment. The nurse specialist in the staging unit at the Royal Marsden Hospital, which is primarily concerned with breast cancer, is responsible for the well-being of patients during their few days' stay and for ensuring that they are fully informed about the tests to be carried out. She also gives the patient and her relatives emotional support and reassurance about treatment. The nurse provides the patient with some continuity of care when she comes to the unit for check-ups or is admitted for treatment. Additional information obtained by the nurse specialist may be valuable to the medical team in planning a course of treatment. All investigations at the unit are carefully documented and the nurse has the responsibility of checking that they are repeated at appropriate intervals after discharge. She also needs co-operation from the staff of the general wards.

CARDIOLOGY

See also Abstract No. 85

127. FRIEDMAN, E. **Hospitals seek to share ECG systems.** *Hospitals*, Chicago, 1978, July 1, vol. 52, no. 13, pp. 99-100, 102.

In planning and implementing the installation of their computerized electrocardiography systems, St. Mary of Nazareth Hospital, Chicago, and Toledo (Ohio) Hospital have incorporated access to the systems for other hospitals. With minimal

expenditure, a sharing hospital can be connected to the St. Mary system by: (i) purchasing a three-channel ECG trolley which can be linked to the central computer via the normal telephone lines; (ii) using its own trolleys and installing a terminal connected directly to the computer; or (iii) receiving unconfirmed reports that would later be read by St. Mary cardiologists, who would send confirmations back to the sharer through terminals or by post or telephone. At Toledo Hospital, several hospitals tap into the system using their own trolleys for unconfirmed readings which are interpreted by their own or Toledo Hospital physicians.

UROLOGY

128. OGG, C. S. **Nephrology.** *Update*, London, 1978, Aug. 15, vol. 17, no. 4, pp. 469-472, 474, 476, 478-479.

Developments over the last 10 years in the management of renal disease are reviewed, with particular reference to chronic renal failure. There is now no good medical reason why co-operative, active and otherwise fit patients between the ages of five and 70 should not be considered for maintenance haemodialysis. The increase in the number of haemodialysis units in Great Britain has not kept pace with that in other European countries; about two out of three patients who could reasonably benefit from it are not being offered treatment. After a period of training in hospital, most patients now dialyse themselves at home. The trained dialysis nurse has emerged as a professional member of a team able to act on her own initiative. Survival is surprisingly good—80 per cent at five years; approximately 90 per cent of patients are able to return to their former occupations. Treatment remains extremely expensive. Renal transplantation has shown a similar, though less dramatic, increase in Europe; Great Britain compares favourably with the European average, though it is still below the achievement of some countries.

129. BAZZATO, G. and others. Dialisis domiciliaria. **[Home dialysis: four years' experience.]** *Policlinica*, Barcelona, 1978, July/Aug., no. 48, pp. 34-36, 39-40, 43, 44.

The authors describe four years' experience with home dialysis in 57 patients with chronic renal insufficiency of varying aetiology who were aged between 17 and 61 years. Most of the patients lived within a radius of 50 km. of the hospital in Philadelphia but one lived in Paraguay. The equipment used was the Kolff kidney and a total of 14,322 dialyses was done in the four-year period. The average life of the cannulas was 10.9 months and that of the pipes 1.28 months. There was a high incidence of breakdown of dialysis units, and other technical complications included disconnection of the shunt (0.63 per cent) or errors in the preparation of the dialysis fluid (0.5 per cent). Home dialysis should be seen as one side of a triangle, the other sides being hospital dialysis and renal transplantation.

130. CARRERAS, L. Organizacion de un servicio de nefrologia. **[Organization of a haemodialysis service.]** *Policlinica*, Barcelona, 1978, July/Aug., no. 48, pp. 27-28, 31-32.

The aims of the nephrology department are the prophylaxis of renal disease, treatment (medical, dialysis, transplantation), and teaching. The department includes

out-patient clinics, wards, dialysis rooms, an area where the water for dialysis is de-ionized, a research zone, the transplant theatre, a minor surgery room, and laboratories. The staff and equipment required will depend on the size of the department.

SURGERY

See also Abstract Nos. 40, 128

131. ADLER, M. W. **Changes in local clinical practice following an experiment in medical care: evaluation of evaluation.** *Journal of Epidemiology and Community Health*, London, 1978, June, vol. 32, no. 2, pp. 143-146.

The changes in clinical practice following a randomized controlled trial of early discharge for inguinal hernia and varicose veins are reviewed. In the West Surrey and North-East Hampshire District the mean length of stay for inguinal hernia patients aged 15 to 64 years inclusive was 4.7 days, and for varicose veins patients 3.5 days. This represents a reduction in mean length of stay of nearly half for the two conditions —3.8 and 3.4 days respectively since 1970. However this change was not discovered in two adjacent health districts.

132. ADLER, M. W. and others. **Randomized controlled trial of early discharge for inguinal hernia and varicose veins.** *Journal of Epidemiology and Community Health*, London, 1978, June, vol. 32, no. 2, pp. 136-142.

A randomized controlled trial has been conducted in Farnham and Frimley, approximately 35 miles south of London, into the effects of discharging patients from hospital either 48 hours or six to seven days after operations for inguinal hernia and varicose veins. There was no statistically significant difference in major post-operative complications between the lengths of stay for either of the two conditions. Similarly there was no difference between the two groups of hernia patients in relation to the number of eventual recurrences. There was no difference in length of convalescence between long-stay and short-stay patients in full-time occupations. Savings were estimated at £25.72 per patient. Patients appeared to approve of their treatment, regardless of their length of stay. However, the families of short-stay patients were less enthusiastic in their attitudes towards the policy of early discharge than the families of long-stay patients.

133. SALEM, R. and others. **Emergency geriatric surgical admissions.** *British Medical Journal*, London, 1978, Aug. 5, vol. ii, pp. 416-417.

The emergency surgical workload created by patients aged 80 and over in Reading hospitals was assessed and the results of treatment examined. A retrospective survey of similar patients admitted in 1966 was also undertaken. The overall mortality rate was 20.6 per cent, but when 17 terminal cases were excluded it fell to 12.5 per cent. The patients had an average length of stay in the acute ward of 14.7 days, compared with an average of 8.4 days for all patients. The number of elderly patients admitted as surgical emergencies has doubled in the last 10 years, thereby exacerbating the bed shortage, but the group studied imposed very little extra load on the in-patient geriatric services, as 78 per cent were discharged to their homes and a further 17 per cent went home after a period of convalescence.

MATERNITY

See also Abstract No. 64

134. BALFOUR, R. P. **Use of a portable real-time ultrasound scanner in district antenatal clinics.** *British Journal of Obstetrics and Gynaecology*, London, 1978, July, vol. 85, no. 7, pp. 492-494.

A portable real-time ultrasound scanner was transported to nine district antenatal clinics up to 35 miles away from St. David's Hospital, Bangor, which served as base, in an attempt to obtain information earlier and avoid unnecessary journeys for patients. A total of 100 patients were scanned. During a scanning time of five to 10 minutes, measurement of biparietal diameters were obtained easily, and in most cases diseases of placental location, foetal movement and the foetal spine were located. The scanner was found to be very suitable for transportation and use in a district clinic situation.

DENTISTRY

135. ALLRED, H. **The influence of auxiliaries on the dental undergraduate course.** *International Dental Journal*, Bristol, 1978, June, vol. 28, no. 2, pp. 116-125.

It is generally recognized that it is desirable for dental undergraduates to spend a good deal of their time providing patient care. Actual times taken by undergraduates in providing a given pattern of care at the London Hospital Dental School's 'Polyclinic' revealed that: (i) undergraduates of the same seniority require only one third the time spent operating alone when assisted; (ii) inexperienced junior students working with dental surgery assistants require 78 per cent of the time taken by their more senior colleagues; and (iii) unoccupied time of undergraduates working with assistants is similar to that of practising dentists. It is therefore proposed that a variety of ways of operating involving undergraduates and auxiliary staff should be studied in order to: (i) save time; and (ii) permit undergraduates to accept responsibility for patient care at levels appropriate to their experience.

136. FORDYCE, G. L. **Vocational training—an introduction to postgraduate education.** *International Dental Journal*, Bristol, 1978, June, vol. 28, no. 2, pp. 137-142.

It appears from the statistics available that most dentists who qualify in the United Kingdom do not take advantage of structured postgraduate education. Although the modern dentist is very well educated, he requires more experience in diagnostic and technical skills and in dealing with patients. He must also keep up to date with the regulations relating to the provision of dental services. An experiment, set up in 1977, aimed to: (i) define deficiencies which might hinder the new graduate from becoming a clinician; and (ii) test the feasibility of using new graduates as postgraduate assistants, attending a day release course over one academic year. The course covered topics such as: (i) National Health Service Regulations; (ii) treatment planning and prescribing; (iii) inter-personal skills; and (iv) staff training. Visits were made to practices and dental schools in hospitals. The scheme was considered successful and a further one is taking place in 1978.

137. SCARAMELLA, J. and others. **Nitrous oxide pollution levels in oral surgery offices.** *Journal of Oral Surgery*, Chicago, 1978, June, vol. 36, no. 6, pp. 441-443.

Levels of pollution by nitrous oxide were measured in the air of 10 dental surgeries in Southern California and were found to be lower than previously reported (see also Abstract Nos. 138 and 140). Measurements were related to: (i) samples of air collected from different places at various stages of the operating session; and (ii) re-breathed gas samples obtained from the surgeon and his assistants at the end of the session. The majority of the surgeries studied had minimum pollution, probably owing to the active air-conditioning in the areas tested. As only three hours per week of exposure to nitrous oxide occurred in 75 per cent of the practices surveyed, a good fitting mask, good nitrous oxide hygiene and efficient air-conditioning should be sufficient to keep the level of pollution below 50 ppm without resorting to additional devices.

138. LANE, G. A. **Measurement of anaesthetic pollution in oral surgery offices.** *Journal of Oral Surgery*, Chicago, 1978, June, vol. 36, no. 6, pp. 444-446.

Following reports of widely differing concentrations of nitrous oxide in dental surgeries, (see Abstract nos. 137 and 140) this paper considers some of the problems of measuring nitrous oxide and other anaesthetics in the atmosphere to show how such different results and interpretations may be explained. In this study concentrations of nitrous oxide were measured by gas chromatography. Samples of both ambient air and air to measure 'time-weighted' concentrations were collected by several methods. As concentrations fluctuate considerably, a continuously recording IR (infrared) analyzer provides the most representative data. In surgeries where nitrous oxide is used only about one hour a week, the use of an efficient mask and a throat pack made of polyurethane foam should be sufficient to keep the level of pollution below the permitted level of 50 ppm. Where nitrous oxide is used over three hours a week, the installation of a relatively simple scavenging system would be needed.

139. COHEN, H. J. **The hospital dental unit.** *Dimensions in Health Service*, Ottawa, 1978, July, vol. 55, no. 7, pp. 21-23.

In 1973 the Jewish General Hospital and Herzl Health Centre in Montreal merged, forming the Herzl Family Practice Centre of the hospital. The merger provided the opportunity to develop a new dental unit providing both routine and specialized dental care and facilities for undergraduate dental students and three full-time dentists. The facilities of the unit include surgeries and offices for the three full-time dentists, seven other surgeries, shared laboratory for at least six interns, waiting/reception area, staff lounge, centralized sterilization and darkroom facilities, toilet facilities, recovery area and panorex and cephalometric units. The staff comprises one oral surgeon (department chief), two general dental practitioners, seven dental interns, one sterilization technician, eight dental assistants, one registered nurse, three receptionists, two secretaries and a clinic manager. The total number of annual patient visits is more than the combined total number of visits to the two dental clinics before the merger (7,000). A plan of the unit is included.

140. WHITCHER, C., ZIMMERMAN, D. C. and PIZIALI, R. L. **Control of occupational exposure to nitrous oxide in the oral surgery office.** *Journal of Oral Surgery*, Chicago, 1978, June, vol. 36, no. 6, pp. 431-440.

The suspected relationship between exposure to inhalation anaesthetics, such as

nitrous oxide, and certain health hazards, means that recently developed control methods should be rigorously applied in dental practice. These methods should reduce the concentration of nitrous oxide in the dental suite to 50 ppm, be inexpensive and be easy to use. The newly developed scavenging mask and the air sweep, which dilutes the nitrous oxide in the dentist's breathing area, are described. All suction pumps used for scavenging should be vented to a safe disposal site. Tests on samples of air in the rooms of three different types of dental practice showed that the methods described were the most effective in reducing nitrous oxide concentrations, but continued monitoring of the air should be carried out to confirm the effectiveness of the procedures used.

PSYCHIATRY

See Abstract Nos. 5, 14, 18, 52, 107, 113, 115

141. World Health Organization. Regional Office for Europe. **The future of mental hospitals: report on a working group, Mannheim, 2-5 November 1976.** (ICP/MNH 019 11) Copenhagen, WHO Regional Office for Europe, 1978, [ii], 68pp.

This report presents the findings of a Working Group on the future of mental hospitals covered by the Regional Office for Europe of the World Health Organization as part of its long-term programme in mental health (1970-1983). The meeting reviewed the functions of the mental hospital as a component of the comprehensive mental health system for a community in the light of changing policies. Features considered include: the present situation and trends; recent developments; and the mental hospital in a comprehensive medico-social service system. Three appendices consider trends in psychiatric care from countries in the European Region; the future of the mental hospital in the United States; and present a list of participants.

142. Cox, M. **Structuring the therapeutic process: compromise with chaos—the therapists' response to the individual and the group.** Oxford, Pergamon Press, 1978, xvii, 300pp. £5.00

This book is about the intricate relationship between a conceptual frame of reference and the therapist's 'purposeful' abandonment within it. The author considers in 12 chapters those aspects of the therapeutic process which are inevitable in any therapeutic relationship. He also considers whether the therapist can use his personality on the patient's behalf so that the patient may make progressive emotional disclosures either within a group setting or in an individual setting. Aspects considered include: orientation; terms of reference; sense of self; the therapist's personal world; transference and counter-transference; empathy; the therapist speaks; the patient speaks; boundaries of therapeutic space; numbers within therapeutic space; compromise with chaos; and terminating the therapeutic process. A bibliography of selected topics for further reading, and a list of references to the text are included.

143. Paykel, E. S. **Meeting the needs of mental disorder—in the field of mental illness.** *Health and Hygiene*, London, 1978, April/June, vol. 1, no. 4, pp. 193-196.

The 1975 white paper *Better services for the mentally ill* set the seal on a pattern of

services which has gradually been evolving over some years in Great Britain. The base is a district general hospital psychiatric unit with a relatively small bed ratio of 50 per 100,000, with a day hospital attached and special arrangements for those needing secure provision and for the elderly mentally infirm. This paper examines some problems in the new pattern, including the under-provision of local authority services. It is highly desirable that plans for all services should be made on a local basis, to reflect special local needs rather than purely national recommendations. One of the virtues of joint funding by area health authorities and local authorities is that it should encourage this. If the new long-stay patients are to be accommodated outside the hospital, there will need to be a variety of residential facilities and day centres. Health and social services staff should function in an integrated way in a comprehensive service, so that patients can move easily from one resource to another.

144. AMERICAN HOSPITAL ASSOCIATION. PSYCHIATRIC SERVICES SECTION. **Psychiatric services in institutional settings: selected conference papers.** Chicago, American Hospital Association, 1978, vi, 96pp. $15.75

This publication focuses upon the complexity of care and treatment of the mentally ill and the impact of economic, legal, legislative, political, regulatory and ethical influences upon psychiatric services in the United States. Twenty selected papers from the 1977 annual meeting and workshop of the Psychiatric Services Section of the American Hospital Association are presented. Major aspects considered include: chronic issues; the public-private interface; children's and adolescents' psychiatric services; administration/management as determinants of clinical services; psychiatric peer review; personal and institutional liability and risk management; and legal and ethical issues in psychiatric services.

145. REYNOLDS, D. K. and FABEROW, N. L. **Suicide: inside and out.** Berkeley, Calif. & London, University of California Press, 1976, xi, 226pp. £2.75

This book is based on a study of suicidal patients in two Veterans Administration neuro-psychiatric hospitals. It is in four sections. The first part reviews the literature and provides background information on previous studies of suicide in neuro-psychiatric hospitals. The second part describes the preparation and organization phase of the study, and staff views about suicide patients. The third part presents a complementary view of life in the hospitals from the patients' viewpoints. The fourth part offers a broad framework for understanding suicide before and after admittance to hospital and presents some suggestions for preventing the suicide. Appendices cover security measures, patients' hospital records, hospital rules and psychological tests. A bibliography is included.

146. DARCY, P. T. **Psychiatric nursing today.** *Nursing Mirror*, Sutton, 1978, July 13, vol. 147, no. 2, pp. 31-32; July 20, vol. 147, no. 3, pp. 26-27; July 27, vol. 147, no. 4, pp. 26-27.

The five short papers in this series deal with: (i) protection of patients; (ii) behaviour therapy and the nurse; (iii) care conflicts; (iv) training and career development; and (v) training, with a recommendation for modules based on care factors.

147. GAVER, K. D. and FRANKLIN, J. L. **Accountability in public mental health organizations.** *Community Mental Health Review*, New York, 1978, Jan./Feb., vol. 3, no. 1, pp. 1, 2-11.

Accountability exists whenever there is delegation of authority or responsibility. This review of the recent literature covers: a brief history of accountability; the forms of accountability; and implications for mental health service organizations. It is concluded that accountability for mental health organizations, and particularly for community mental health centres, constitutes a complex, perplexing and changing set of issues which pose critical choices which must be made by the mental health administrator. A list of 74 references to the literature is included, some with annotations.

148. KULDAU, J. M. and ALTO, P. **Effects of a specific programme milieu with employment goals: a pilot study.** *International Journal of Social Psychiatry*, London, 1978, vol. 24, no. 2, pp. 104-116.

Socially-marginal adult male patients were randomly assigned to two units with therapeutic community values at Palo Alto (Calif.) Veterans Administration Hospital. An experimental unit focussed on obtaining employment in the community for patients, while the control unit followed a conventional psychiatric treatment programme. Follow-up hospitalization and employment after one year were the major outcome variables; overall mean differences were not significant, but favoured the experimental unit. Treatment differences interacted with several patient background variables. In particular, the experimental unit's superior employment outcome tended to be concentrated in patients with better prognoses; while its superiority in reducing admission tended to be concentrated in patients with poorer prognoses.

149. COLEMAN, J. V. and PATRICK, D. L. **Psychiatry and general health care.** *American Journal of Public Health*, Washington, 1978, May, vol. 68, no. 5, pp. 451-457.

A study of psychiatric morbidity in the general health care scheme of a Health Maintenance Organization was carried out on the basis of a five-year experience with the Community Health Center Plan of Greater New Haven, Conn. The findings revealed that 15.7 per cent of patients visiting the Health Center over a two-year period had emotional problems; 72 per cent were treated by primary care doctors alone and 28 per cent by mental health doctors. Chronic patients represented two per cent of all patients who visited in 1974; of these 54 per cent were seen by mental health doctors and 46 per cent by primary care doctors. There was an increase in the percentage of non-chronic patients seen by primary clinicians over a two-year period. The use of psycho-active drugs by primary physicians and the advantages and difficulties of developing an integrated mental health service are described.

150. WOLKON, G. H., PETERSON, C. L. and ROGAWSKI, A. S. **A program for continuing care: implementation and outcome.** *Hospital and Community Psychiatry*, Washington, 1978, April, vol. 29, no. 4, pp. 254-256.

The records of the continuing care scheme for psychiatric patients at a large hospital in Los Angeles, Calif., were analyzed to determine the success of referrals for aftercare. A total of 552 patients discharged during an eight-month period were referred for

continuing care, and 418 patients kept their first appointment. Patients were most likely to keep their first appointment if it was arranged for within three days after release from the hospital and if it was confirmed before the patient's discharge from hospital. If an appointment could not be arranged within three days, a telephone call to the patient improved the referral rate.

151. DAVIS, J. E., LOREI, T. W. and CAFFEY, E. M. **An evaluation of the Veterans Administration day hospital program.** *Hospital and Community Psychiatry*, Washington, 1978, May, vol. 29, no. 5, pp. 297-302.

A study of 34 Veterans Administration day hospital programmes for psychiatric patients who had not had prolonged stays in hospitals, and for whom a variety of treatment approaches was required, was carried out to evaluate how well patients reacted three months after admission in relation to nine treatment goals. The study group consisted of 1,410 patients, and 70 per cent of the group had follow-up interviews. The study revealed that treatment was successful in all areas except in promoting economic independence: it was most effective in reducing perceptual-cognitive disfunctions, emotional disturbances and inter-personal difficulties.

152. WEINBERG, J. Curium als opvanginstituut voor ernstig gestoorde kinderen en jeugdigen. **[The Curium psychiatric centre and school, Oegstgeest, for seriously disturbed children and young people.]** *Ziekenhuis*, Utrecht, 1978, July 19, vol. 8, no. 14, pp. 372-374.

The centre caters for children who are too disturbed to be educated at home but who do not need admission to psychiatric hospitals. The centre is like a small village community with six houses and a special school. The object is to create an atmosphere of basic home security which so often is lacking for these children in their own homes. The treatment is in principle preventive by admitting children at risk at an earliest possible age; by trying with special school treatment to prevent disturbances getting worse; and by trying with appropriate treatment to prevent disturbances in later life. The children are divided into six groups according to age and problems, including a group for adolescents preparing for return to society and a group for observation and short-term treatment (one to three months). Each group lives like a family in a house under supervision of a group leader. Each group of nine has a group family therapist who monitors relations and keeps in contact with the children's parents. It is stressed that children are only admitted after all other attempts, such as out-patient attendance or change of home environment, have failed. The paper includes two pictures.

153. GREENE, J. **Discharged and be damned: the nursing response.** *Royal Society of Health Journal*, London, 1978, June, vol. 98, no. 3, pp. 104-107.

Developments in psychiatric nursing, particularly in community psychiatric nursing, are outlined. The role of the psychiatric nurse and the work that can be done by community psychiatric nurses but not by others are discussed. It is claimed that psychiatric nursing has adjusted to meet the changing needs of the mentally ill. A major problem is the lack of a unified policy in relation to the admission, treatment and general management of difficult patients. There needs to be some formal way in which the nursing staff can be put in the picture and discuss likely problems before the admission of such patients take place. There would be less public anxiety about the

discharge of mentally ill patients, particularly long-stay and difficult patients, if each hospital had a policy in which agreement could be reached as to whether facilities existed for the adequate after-care of those patients who need continued support and supervision.

154. KENWORTHY, J. **A development assessment approach to social competence in profoundly handicapped adults—a pilot study.** *British Journal of Mental Subnormality*, Birmingham, 1978, June, vol. 24, part 1, no. 46, pp. 13-28.

The Special Primary Progress Assessment Chart (S/P=P-A-C) is the latest addition to the range of P-A-Cs currently used for assessment of social competence in the mentally handicapped and is designed to extend the facility of the P-A-C format to the profoundly handicapped. Fifty profoundly handicapped patients at Chelmsley Hospital, Birmingham, were assessed using the S/P=P-A-C. Two lines of investigation were opened. The first concerned the use of developmental ages obtained from the various sectors of the S/P=P-A-C to construct a social competence profile for the sample. It is suggested that the profile will provide a reference point for the examiner who wishes to assess his own cases of profound handicap using the same method. The second concerned the identification of patterns of inter-item consistency amongst the S/P=P-A-C sectors. The sample records were compared with the predicted patterns to identify items which as a rule, 'go together' in the case of a profoundly handicapped individual. Predicted consistencies which were found to hold true for the sample have been tabulated to provide a check of 'performance-consistency' in future assessments. In many instances the sample records failed to agree with the predicted consistency patterns. An explanation for these findings is offered which, if validated in further study, may prove to be of considerable aid in setting training objectives for the profoundly handicapped hospital resident.

155. WORLD HEALTH ORGANIZATION. REGIONAL OFFICE FOR EUROPE. **Care of the mentally retarded in the community: report on a conference, Santiago de Compostela, 25-29 June 1974.** (ICP/MNH 029 1 (ex EURO 5440 1)) Copenhagen, World Health Organization, Regional Office for Europe, 1978, [iv], 89pp.

The conference on the Care of the Mentally Retarded in the Community organized by the Regional Office for Europe of the World Health Organization was held to review the extent, nature and organization of education, health, social and voluntary services for the mentally retarded and to consider the advantages and disadvantages of different patterns of care. The report of the conference is in seven sections: introduction, scope, assessment of the nature of the problem; integration of the mentally retarded into the social life of the community; resources required; voluntary organizations; and co-ordination. Nine appendices are included: the epidemiology of mental retardation; the care of the mentally retarded in France; services for the mentally retarded in Spain; Swedish experience with community-based services for the mentally retarded; the network of medical, paedagogical and rehabilitation services for the mentally retarded in the USSR; patterns of care for the mentally retarded in the United Kingdom; work of voluntary organizations; tasks, role and importance of parents' associations; and a list of participants.

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